THE AMERICAN JOURNAL of OCCUPATIONAL THERAPY

OFFICIAL PUBLICATION OF THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

Vol. XII, No. 4, Part I 1958 July-August

OT Dept

Part I
Program for 1958 Conference

TABLE of CONTENTS

ARTICLES

DIVISIONS

FEATURES

Copyright 1958 by the American Occupational Therapy Association
New York 19, New York, Published bi-monthly.

This is Part I of a two-part issue.

REPRINTS*

from the

American Journal of Occupational Therapy

available from

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

250 West 57 Street, New York 19, N. Y.

Hurt, Sue P., O T.R. "Considerations in Muscle Functions and Joint Measurement." I, 2, 4, 5, 1947; II, 1, 1948, 45c.

Newman, M. K., M.D.; S. Radlow, R.P.T.; B. Jewett, O.T.R. "Multiple Sclerosis." IV, 5, 1950, 15c.

Duvall, E. N., Ph.D. "Research." VI, 3, 1952.

Svensson, V. W., O.T.R.; M. C.Brennan, O.T.R. "Apparatus Aids." VII, 1, 1953.

Brandt, Hyman, Ph.D. "Research—A Guidepost for Growth." VII, 2, 1953.

Svensson, V. W., O.T.R.; M. C. Brennan, O.T.R. "The Opponens Splint." VII, 2, 1953.

Brown, M. E., M. A., R.P.T.; M. Van der Bogert, O.T.R. "Prevocational Motor Skill Inventory." VII, 4, 1953.

Svensson, V. W., O.T.R.; M. C. Brennan, O.T.R. "Adapted Equipment." VII, 4, 1953.

Koven, B., M.D.; F. Shuff, O.T.R. "Group Therapy with the Chronically Ill." VII, 5, 1953.

Robinault, I., O.T.R., M.A. "Occupational Therapy Technics for the Pre-school Hemiplegic—Toys and Training." VII, 5, 1953.

Svensson, V. W., O.T.R.; M. C. Brennan, O.T.R. "Some Uses of the Suspension Sling in the Treatment of Poliomyelitis." VII, 5, 1953.

Svensson, V. W., O.T.R.; M. C. Brennan, O.T.R. "Adapted Equipment for a Severely Involved Poliomyelitis Patient." VII, 6, 1953.

"Teaching of Writing to Cerebral Palsied Patients." VII, 6, 1953.

Whitehouse, F., Ed.D. "Rehabilitation Center." VII, 6, 1953.

"Dressing Techniques for the Cerebral Palsied Child." VIII, 1, 1954.

Robinault, I, O.T.R., M.A. "Perception Technics for the Pre-school Cerebral Palsied." VIII, 1, 1954.

Svensson, V. W., O.T.R.; M. C. Brennan, O.T.R. "Adapted Weighted Resistive Apparatus." VIII, 1, 1954.

Boynton, B. L., M.D. "Refining our Resources." VIII, 2, 1954.

"Dressing Techniques for the Cerebral Palsied Child—Part II, Fastenings." VIII, 2, 1954.

Svensson, V. W., O.T.R.; M. C. Brennan, O.T.R. "Adapted Equipment." VIII, 2, 3, 1954.

Goodrich, D. Wells, M.D. "The Present Status of Research in Occupational Therapy." VIII, 4, 1954.

Svensson, V. W., O.T.R.; M. C. Brennan, O.T.R. "A Prosthetic Grasping Mechanism." VIII, 5, 1954.

Welch, Mary, Capt., AMSC (OT). "Training of Upper Extremity Amputees." VIII, 5, 1954.

Gordon, E. E., M.D. "Does Occupational Therapy Meet the Demand of Total Rehabilitation." VIII, 6, 1954.

Wortis, H. Z.; William Cooper, M.D.; M. P. Simonson, O.T.R. "The Home Visit in a CP Treatment Program." VIII, 6, 1954.

McDaniel, Myra, Major, AMSC (OT). "The Role of the Occupational Therapist in the Reeducation of Asphasia Patients." VIII, 6, IX, 1, 2, 1955.

Barton, Walter E., M.D. "Medical Supervision in Occupational Therapy." IX, 2, 1955.

Forrer, G. R., M.D. "Work Therapy Program at Northville State Hospital." IX, 4, 1955.

Frye, G. D., O.T.R.; Harold Shalik, O.T.R. "Selecting and Utilizing the Occupational Therapy Aide." IX, 4, 1955.

Sokolov, June, O.T.R. "Working as a Team." IX, 6, 1955.

Best, H. L.; Sol Charen. "The Value of Occupational Therapy with Hospitalized Tuberculous Patients." X, 3, 1956.

Stattel, Florence M., M.A., O.T.R. "Equipment Designed for Occupational Therapy." X, 4, 1956.

Brower, L. M., M.A., O.T.R. "Factors Inhibiting Progress of Cerebral Palsied Children." X, 6, 1956.

Dixey, Eileen, O.T.R.; G. M. Haslerud, Ph.D.; N. C. Brown. "The Effect of the Professional Activity of Occupational Therapists on the Behavior of Mental Patients." X, 6, 1956.

Azima, H., M.D.; E. D. Wittkower, M.D. "A Partial Field Survey of Psychiatric Occupational Therapy." XI, 1, 1957.

Fidler, Gail, O.T.R. "The Role of OT in Multi-discipline Approach to Psychiatric Illness." XI, 1, 1957.

Redkey, Henry. "The Function and Value of a Pre-Vocational Unit in a Rehabilitation Center." XI, 1, 1957.

Sokolov, June, O.T.R. "Therapist into Administrator—Ten Inspiring Years." XI, 1, 1957.

*Individual reprints sell for 20c each unless otherwise specified.

THEY *CAN* LEARN TO WRITE . . . AND EARN MONEY WRITING . . .
It's easier than they think!
low-cost individual instruction-by-mail helps them develop their natural ability *right-at-home!*

WORKSHOP SCHOOL FOR WRITERS, developed by a group of famous novelists, magazine and book editors, makes it possible for you to learn to write *at your own speed at home.*

Creative principles underlying salable writing reduced to simple terms, brought down to earth, with this easy-to-understand thorough course of instruction by mail.

You learn, step by step, how to ferret out from the recesses of your memory and experience, the ideas, the characters and the incidents that form the basis of good plots.

You learn what editors will and will not buy, what to avoid and what to strive for, and where and how you can market your stories.

You learn the techniques for writing salable stories by doing specific, carefully-planned assignments, and your work is evaluated, analyzed and appraised with each assignment, in order to lead you directly up the path to writing stories that sell.

WORLD FAMOUS NOVELIST, P. G. WODEHOUSE, creator of Jeeves says of the WORKSHOP SCHOOL FOR WRITERS . . .
"I cannot imagine a clearer and better guide to writing for the magazines than this Workshop School Correspondence Course. There are very few authors, whether beginners or old pros, who could not pick up something useful from it. I know if I had had it by me when I first took typewriter in hand fifty-odd years ago, I should have been spared considerable nervous strain, as Bertie Wooster would say. It covers every aspect of the writing game and points out the snares and pitfalls.

Send for free booklet and detailed information. No charge or obligation.
MAIL COUPON NOW

THE WORKSHOP SCHOOL FOR WRITERS
521 Fifth Avenue, New York 17, N. Y.

THE WORKSHOP SCHOOL FOR WRITERS OT-1
521 Fifth Ave., New York 17, N. Y.
Please send me, without cost or obligation, more information on your "Writing-at-Home Course."
Mr. Mrs. Miss _____
Street _____
City _____ Zone ____ State _____
Inquiries confidential. No salesman will call. Approved by the New York State Education Department.

Everything for the Handweaver

HIGH QUALITY *Lily* HANDWEAVING YARNS AND SUPPLIES

COTTONS • WOOLS • HOMESPUNS
LINEN • METALLICS • CHENILLES
NOVELTY YARNS

Looms, including the Leclerc Folding Loom
Warping Frames
Bobbin racks and winders
Table reels Tension boxes

PROMPT SHIPMENTS

Send $1.00 for complete color cards. This $1.00 can be applied to your next order of $10.00.

Write today for free catalog and current price list

Order all your handweaving supplies from the Handweaver's Headquarters

LILY MILLS COMPANY
Dept. HWN, Shelby, N. C.

The American Journal of Occupational Therapy

The Official Publication of the

American Occupational Therapy Association

Editorial Office: 3514 N. Oakland Ave.
Milwaukee 11, Wis.

EDITOR

Lucie Spence Murphy, O.T.R.

ASSOCIATE EDITORS

Marie Louise Franciscus, O.T.R., Lt. Col. Myra McDaniel, O.T.R.

EDITORIAL STAFF

ADVISORY COMMITTEE

Pediatrics.....H. Kent Tenney, M.D.
University of Wisconsin Medical School
Physical Medicine .....Ben L. Boynton, M.D.
Northwestern University
Psychiatry .....Walter S. Barton, M.D.
Boston State Hospital
Research .....D. Wells Goodrich, M.D.
N. I. of M. H., Bethesda, Md.
Tuberculosis .....A. L. Banyai, M.D.
Chicago, Illinois
Editorial .....William R. Dunton, Jr., M.D.
Baltimore, Md.

DIVISION EDITORS

A. Jean Ayres, O.T.R.
Mary Britton, O.T.R.
Elizabeth Collins, O.T.R.
Eunice Ford, O.T.R.
Evelyn M. Goddard, O.T.R.
Angeline Howard, O.T.R.
Eleanor Kille, O.T.R.
Barbara Locher, O.T.R.
Henrietta McNary, O.T.R.
Martha Norris, O.T.R.
Bertha Piper, O.T.R.
Adaline Plank, O.T.R.
Eleanor R. Hillger, O.T.R.
Harold Shalik, O.T.R.
Norma Smith, O.T.R.
Florence Stattel, O.T.R.
Beatrice Wade, O.T.R.
Elizabeth M. Wagner, O.T.R.
Carlotta Welles, O.T.R.
Wilma West, O.T.R.
Minnie Witham, O.T.R.
Ruth Woodring, O.T.R.

CONTRIBUTING EDITORS

Virginia Caskey, O.T.R.
Marjorie Fish, O.T.R.
Virginia Kilburn, O.T.R.
Winifred Kahmann, O.T.R.
Frances L. Shuff, O.T.R.
Ruth Robinson, Lt.Col.
Clare Spackman, O.T.R.
Caroline Thompson, O.T.R.
Muriel Zimmerman, O.T.R.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

250 West 57th Street, New York 19, N.Y.

OFFICERS: *President:* *Lt. Col. Ruth Robinson, AMSC; *President-elect:* Helen Willard, O.T.R.; *First Vice-President:* *Beatrice D. Wade, O.T.R.; *Second Vice-President:* Florence Stattel, O.T.R.; *Treasurer:* *Wilma West, O.T.R. BOARD OF MANAGEMENT: *Delegates:* Marion Crampton, O.T.R. Jeannine Dennis, O.T.R., *Margaret Mathiott, O.T.R., Frances Miller, O.T.R., Margery Peple, O.T.R., Jacqueline Wright, O.T.R. *Elected members:* Marguerite Abbott, O.T.R., *Mary Britton, O.T.R., Ruth Brunyate, O.T.R., Gail S. Fidler, O.T.R., *Marie Louise Franciscus, O.T.R., Lt. Col. Myra McDaniel, O.T.R., Elizabeth Messick, O.T.R., *Laurel Nelson, O.T.R. Mary Reilly, O.T.R., Ivabelle R. Rhodes, O.T.R., June Sokolov, O.T.R., Caroline Thompson, O.T.R.; *Honorary Board Member:* William R. Dunton, Jr., M.D.

*Members of the executive committee.

EXECUTIVE DIRECTOR: Marjorie Fish, O.T.R., 250 West 57th Street, New York 19, N. Y.

Correspondence relating to editorial matters should be sent to *The American Journal of Occupational Therapy*, 3514 N. Oakland Ave., Milwaukee 11, Wis. Only original contributions should be submitted for publication in the Journal and if accepted, may not be published elsewhere without permission.

Opinions and statements expressed in the magazine are those of the authors of articles and are not to be considered as representing the views of the American Occupational Therapy Association.

Manuscripts should be typewritten, double spaced, with liberal margins and submitted in duplicate. References should be listed at the end of the article and not as foot notes.

Illustrations may be included. Photographs should be glossy prints 3" x 5" or larger. Drawings must be drawn and lettered in India ink on heavy paper.

Correspondence relating to subscriptions should be sent to the American Occupational Therapy Association, 250 West 57th Street, New York 19, N. Y. Change of address notices should include the old as well as the new address, postal zone, and should be mailed six weeks in advance of publication date.

The Journal is published bimonthly on the 10th of February, April, June, August, October and December.

Subscription price to members included in yearly fees; to non-members $5.00 a year domestic, $5.50 foreign. Single issues, $1.00.

Correspondence relating to advertising should be sent to the editorial office. Classified advertising accepted only for job opportunities or positions wanted.

Entered as second class matter at Post Office, Milwaukee, Wisconsin, under the act of March 3, 1879.

PRESTON **EQUIPMENT FOR** REHABILITATION · *A Complete Line* · PHYSICAL THERAPY · OCCUPATIONAL THERAPY

- **SELFHELP DEVICES:**
  Devices for one-armed knitting, embroidery and darning; Telephone Holders; Automatic Page Turners; Flatware for the Handicapped; Drinking Aids; Dressing Aids; Reachers; Bathtub Rails and Seats; Toilet Armrests; Grab Bars of various designs; Raised Toilet Seats; Incontinent Devices.
- **AIDS FOR THE HANDICAPPED:**
  Wheelchairs, custom built and standard; Commodes; Walkers; Tilt Tables; Large selection of Crutches and Canes, including Tripod and Four-Legged Canes.
- **CEREBRAL PALSY EQUIPMENT:**
  Relaxation Chairs; Runner Chairs; Cut-Out Tables; Stand-In Tables; Foot Placement Ladder; Standing Stabilizers; Straight and Reciprocal Skis; Crawler; Special Tricycles.
- **SPEECH THERAPY:**
  Audiometers; Tape Recorders; Auditory Training Units; Chromovox; Mirrors.
- **REHABILITATION EXERCISE:**
  Walking Parallel Bars and Exercise Staircases; Posture Mirrors; Gymnasium Mats; Bicycle Exercisers; Restorator; Progressive Resistance Exercise Units; Quadriceps Boots; N-K Table; Guthrie-Smith Suspension Apparatus; Shoulder Wheels; Manuflex; Kanavel Table.
- Complete Line of Bunnell Hand & Finger Splints; Keystone Splint; Cervical and Pelvic Traction; Whirlpools; Heat Lamps; Ultrasound; Hydrocollator; Goniometers; Dynamometers; Treatment Tables; Timers; ADL Training Boards.

Send for your free copy of our illustrated Catalog No. 1058-O

J. A. PRESTON CORPORATION
175 FIFTH AVENUE, NEW YORK 10, N. Y. ORegon 4-9044

We now carry a full line of the remarkable

CHENILLE
WIRE MATERIALS
AND PROJECTS
for OT

Excellent for finger dexterity, ideal for creative expression, unexcelled for supplemental income when needed. Will fit any level of patient activity.

WHATEVER
YOUR
PROGRAM

Chenille animals and pins will kindle a new enthusiasm.

Send for your free brochure today

S. & S. Leather Company, Inc.
Colchester 44, Conn.
Specialists in handicrafts for the OT

JUST THE THING YOU WANT

Have a copy of Hammett's Catalog handy . . . it lists and illustrates the latest in occupational therapy materials and supplies. It's free!

LOOMS
Hand or Foot Power
WEAVING MATERIALS
Rug Roving, Cotton Yarn
Carpet Warp, Rug Yarns
BASKETRY MATERIALS
Reed, Raffia, Cane
Wooden Bases and Trays
Corkcraft
ART MATERIALS
Leather and Tools
Books of Instruction

WRITE FOR YOUR FREE OCCUPATIONAL THERAPY CATALOG TODAY!

J. L. HAMMETT CO.
Educational Materials Since 1863
306 Main Street **Cambridge, Mass.**

Speed progress in ADL

Patients with upper extremity disabilities gain self-reliance with these OT designed products. They speed the return of muscular function and promote and encourage individual self-care—ideal for hemiplegic, quadriplegic, post polio patients, and many others.

Tomac Wheel Chair Table

TOMAC WHEEL CHAIR TABLE

With virtually unlimited adjustment possibilities, the Tomac Wheel Chair Table is ideal for work, eating or recreation. Unsurpassed for strength—it's sturdy enough to even support an electric typewriter. In an extreme raised position (10″), it's ideal for patients requiring almost complete arm support. Also tilts up to 35°.

Fits any make wheel chair easily and quickly by secure spring clamps. No space is lost between the double-tops for cumbersome raising devices. Extra-large top is 28″ x 28″ with 16″ x 8″ cut-outs.

No. 5215—Wheel Chair Table, ⅜″ plywood top, each **$39.50**

No. 5215A—Same, except ⅜″ Masonite top, each **37.50**

ARM SLING SUSPENSION

Helps prevent deformity and encourages activity. Excellent support for patient's arm to facilitate self-feeding, exercising and ADL.

Fits any tubular wheel chair with quickly installed bracket. Overhead support rod easily removed when sling is not in use. Sling assembly is adjustable to any position along overhead stainless steel rod. Comfortable leatherette slings adjust to any patient—adult or child.

No. 496-993-1—Arm Sling Suspension, each **$12.50**

Arm Sling Suspension

Ball Bearing Feeder

BALL BEARING FEEDER

Assists the patients not only in self-feeding, but in many other necessary Activities of Daily Living. This feeder (Warm Springs' type) works on the principle of balance and gravity elimination by means of friction-free ball bearings. Patient can feed himself, write, read or paint with minimum effort.

All steel except for aluminum trough. Over-all dimensions when folded, 15½″ long, 3½″ high, 4½″ wide. Weighs 2 lbs. Specify for right or left hand.

No. 5220—Ball Bearing Feeder, adult **$37.50**

No. 5221—Same, but with Adjustable Chair Bracket for reclining wheel chairs **50.00**

No. 5222—Ball Bearing Feeder, child **37.50**

Order these Occupational Therapy aids and other rehabilitation needs from:

Rehabilitation Products

A Division of American Hospital Supply Corporation, 2020 Ridge Ave., Evanston 22, Illinois, **Dept. 24**

Regional Sales and Distribution Centers

ATLANTA • Chamblee, Ga.
CHICAGO • Evanston, Ill.
COLUMBUS • Columbus 6, Ohio
DALLAS • Dallas 19, Texas
KANSAS CITY • N. Kansas City 16, Mo.
LOS ANGELES • Burbank, Calif.
MINNEAPOLIS • Minneapolis 12, Minn.
NEW YORK • Flushing 58, N.Y.
SAN FRANCISCO • South San Francisco, Calif.
WASHINGTON • Washington 18, D.C.

THE AMERICAN JOURNAL

of

OCCUPATIONAL THERAPY

Official Publication of the American Occupational Therapy Association

July-August 1958 Part I. Vol. XII, No. 4

THE PRESCRIPTION

An Anachronistic Procedure in Psychiatric Occupational Therapy[1]

JUNE MAZER, O.T.R.[2]

WELLS GOODRICH, M.D.[3]

Over several years we have been exploring various problems which face occupational therapists who work with psychiatric patients. During these exploratory studies in a number of private and public hospitals we have become increasingly impressed that, as a form of medical supervision, the prescription is not fitted to the modern collaborative team organization for providing psychiatric treatment. In informal conversations with staff members from various other hospitals and clinics we appear not to be alone in viewing the prescription as an anachronistic form of staff communication, although the literature reveals only limited recognition[1,12] of this present changing state of affairs within the role relationship of the occupational therapist to the psychiatrist.

Traditionally, within the profession of occupational therapy, the prescription has been and is still a symbol of a close working relationship with the physician, as well as an important form of medical supervision. We have no wish to weaken the bonds of communication between the busy psychiatrist and the busy occupational therapist. Quite the contrary, we wish to strengthen these bonds; but we are convinced that the prescription itself can operate as a hindrance. When taken seriously, the prescription tends to be a substitute for more adequate forms of staff communication and staff decision making.

This paper will present the bases for our belief that, where no physical disability is involved, other forms of communication and supervision are more appropriate than the prescription. Staff attitudes inherent in the acts of giving prescriptions or of receiving prescriptions foster a different type of professional relationship between the physician and the occupational therapist than pertains in the mental health team between the physician and the social worker or the psychologist. While the authoritative-dependent relationship is appropriate to the operating room or to the general problems of patients' physical care, it operates to inhibit rather than encourage communication and performance by the psychiatric team. Azima and Wittkower[1] make an interesting comment relevant here: "The relative lack of occupational therapist—psychiatrist relationship is partly due . . . to the anxiety of some psychiatrists because of their difficulty in performing the role of authority expected from them." Discussion of these issues will be illustrated with references to our recent study[2] carried out at a private mental hospital. The relevant literature will also be referred to briefly.

VARIOUS DEFINITIONS OF THE PRESCRIPTION

To illustrate the confusion which has developed in the use of the term "prescription" in the field of psychiatric occupational therapy, a few quotations may be useful. Webster's dictionary[3] defines a prescription as: "A written direction for the preparation and use of a medicine." A current medical dictionary[4] provides a similar definition: "Written instructions designating the preparation

1. Assistance in preparing this article for publication was given by the Chestnut Lodge Research Institute under its grant from the Ford Foundation.

2. Occupational therapist, activity dept., Chestnut Lodge, Rockville, Maryland.

3. Psychiatrist, National Institute of Mental Health, Bethesda, Maryland.

and use of substances to be administered." The predominant view of the prescription as applied in psychiatric occupational therapy is that a specific description of the patient's problems and of the therapeutic goals should be provided by the psychiatrist. This view was expressed by Dunton[5] in the pioneering manual, "Prescribing Occupational Therapy." Barton[6] and Fidler and Fidler[7] have expressed a similar viewpoint. The recent American Occupational Therapy Association Project[8] was also in agreement: "A prescription includes statistical information, a statement of emotional problems and needs, therapeutic goals and special technique, procedures and precautions. It does not include specific designation of media."

If one genuinely expects to be able to write such a prescription, one has failed to take account of two facts: (A) psychiatrists and psychologists have no way of determining early in treatment, except in a very superficial manner, the needs, problems and behaviors which will face the occupational therapist in dealing with a patient, and (B) it will be years, if ever, before the psychological properties of activities and group situations are well enough understood that "special techniques" and precise occupational therapy "procedures" and "goals" can be prescribed *in advance* with any reliability. True, often after an initial interview, the psychiatrist may be in a position to classify the patient's disturbance as to type and severity, to set up the broad outlines of a treatment program and even to hazard a prognosis. On the other hand, if a patient has cardiac failure or abdominal pain, a single physical examination frequently can provide the internist or surgeon with sufficient information to prescribe a specific quantitative dosage of a drug. If the patient has a psychiatric disorder, a single interview or a psychological test cannot provide—and possibly never will provide—sufficient information to predict the specific needs, specific problems and specific behavior, which will be elicited by the occupational therapy situation.

The occupational therapist needs information about the patient as early as possible following admission. In some OT departments today the written prescription is the occupational therapist's main source of information from the doctor. Understandably, he has been unwilling to risk losing this vital source of information and consequently slow to re-examine this traditional crutch of the profession. However, even in large hospitals, where information and communication may be scarce, admission notes prepared by social service and by the admitting physician would provide more adequate information. Another promising procedure has been suggested,[9] namely for the occupational therapist himself to conduct a specially structured interview in order to obtain the patient's vocational and avocational history and other information useful in planning an activity program.

Current thinking about the prescription can be further specified by referring to Elkins, Van Vlack, and Marcil's recent article.[10] We would agree with much that these authors have to say, particularly their emphasis upon the personality of the therapist as an important instrument of treatment. But the following seems to be misconceived:

> "Usually a statement can be made in a single sentence which attempts to relate the defensive purposes of the patient's behavior to his fundamental feelings. For example, both the psychiatrist and the occupational therapist must understand why a particular patient acts in a withdrawn manner. Is he acting withdrawn because he feels overwhelmed by his own anger and fear; because he feels useless, unwanted, or unworthy; because he feels omnipotent; because he feels different sexually, or socially or merely because he knows he is ill."

In actuality, no "single sentence" could provide such information at a practical level of specificity. The profession of social work has recognized this by relying upon regular conferences for supervision. Nursing and occupational therapy also have been, of course, moving in the same direction. Barton implicitly supports this concept of supervision and communication in one discussion of prescriptions:[6]

> "A more elaborate (prescription) form in psychiatric disorders would provide a dynamic interpretation of the patient's illness and his needs and may offer suggestions, in some detail, as to the therapist's role in establishing relationships. Such information is tedious to record and is best conveyed verbally."

Huntting and Semrad[11] open an informative theoretical paper with a statement which further illustrates the current confusion in the use of the words *prescribing* and *prescription:* namely,

> "The prescribing of occupational therapy for a mental patient cannot be accomplished by the doctor's writing out a prescription."

(Why call it prescribing, then?) The article goes on to shed considerable light on the ways occupational therapy functions to relieve patients' anxiety, to develop patients' ego skills and to provide patients with meaningful human relationships.

These authors as well as Azima and Wittkower[1] seem to believe that, while it is impossible now to prescribe OT, conceivably in the future it may be possible to do so. The following quote is from the latter authors:

> "The general aspect of this proposition (prescribed occupational therapy) may be attributed to the nebulous character of its underlying concept. It is difficult to conceive how one can prescribe definitely for such labyrinthine complexities as mental disorders. *In the present*

*state of our knowledge** it seems unlikely that one can prescribe healing activities as one does healing medications."

And from Huntting and Semrad:[11]

"How such treatment can be prescribed cannot be answered until the psychiatrist and occupational therapist can cooperate in *research which will allow them to know specifically the function of activity and their indications in a specific situation geared to the mental state of the patient at the moment**, so that the patient can proceed in recovering his optimum ego potential."

Even after needed research has been carried out and even when, at long last, we do have more useful understanding of the psychological and social properties of activities, we would emphasize that the prescription will not be appropriate. Indeeed, as research adds new dimensions to our understanding of activities, the result undoubtedly will be to strengthen the contribution of the occupational therapist to the psychiatric team and to clarify the fact that the psychiatrist is an advisor to and collaborator with the OT as he is with the psychologist and the social worker. In such a professional relationship when dealing with issues as complex as face the psychiatric team, only forms of communication which permit face-to-face sharing of ideas and observations are adequate to the task. In instances where a face-to-face conference is not feasible, the best alternative would seem to be for the occupational therapist and psychiatrist to share with each other their form of communication.

A recent study by Neubauer and Beller[12] has demonstrated that personnel, such as teachers, nurses or occupational therapists, who are in direct daily contact with patients, are in a better position to evaluate patients' current ego functioning and current behavioral problems than the clinician who sees the patient in interviews. On the other hand, the clinician through interviews has greater opportunity to evaluate hidden conflicts and etiologic forces. Thus, Neubauer and Beller's findings support the concept that in the psychiatric treatment team, the occupational therapist and psychiatrist have complementary rather than hierarchial roles in diagnosis and in treatment.

THE NATURE OF PSYCHIATRIC OCCUPATIONAL THERAPY

Experience has suggested that use of the prescription in psychiatric OT attempts to oversimplify the activity situation and tends to limit the role of the occupational therapist. In our own study[2] of attempts to involve psychiatric patients in activities, our attention was frequently caught by two general factors: *the complexity of the therapeutic activity situation and the rapidly-shifting nature of the activity therapists' role.*

A number of episodes of such diverse activities as sketching, wall painting, story reading, library cataloguing, trips to the theatre and play production were collected. These observations were made in a hospital where no theoretical or administrative distinction is made between recreation therapy and occupational therapy and where the therapist has considerable freedom to be flexible in his choice of activities. In observing and analyzing the therapeutic functions of the occupational therapist in action during these episodes, we did not attempt to keep track of all the possible therapeutic influences of his work. Our inquiry was limited to staff work as it aimed "to provide the patient's disabled personality with ego-supportive and ego-growth experiences."[2]

An abstract from an activity episode from this study follows. It will illustrate some of these issues. In this instance the activity therapist helped a ward group repaint their living room.

The ward group had decided, in their weekly ward conferences with their administrative physician, which the OT attended, that they wanted to redecorate the living room and what color they wanted to paint it. Materials were supplied by the hospital paint shop. The OT's goal was to help this patient group to complete a planned co-operative enterprise; namely, to repaint the living room. (The living room was actually a kind of dayroom located in an unlocked building and frequently used as a gathering place by other in-patients and out-patients.) The painting was started one day shortly after lunch by one of the ward patients, one out-patient, and the occupational therapist. Ned, the out-patient, worked efficiently and effectively on his own for the first half hour and then had to leave for a doctor's appointment. Clare, the first ward patient to arrive, stroked the wall several times with the paint roller, splashed paint all over herself, and quit, complaining that it was too tiring. She immediately cleaned all the paint off herself fastidiously, utilizing a great deal of energy with the turpentine rag. The occupational therapist, sensing that the problem might be Clare's uncomfortableness at getting so messy, suggested that Clare use the trim brush and be very careful not to drop any paint on the baseboards. Clare did most of the tedious trim painting, working for most of the afternoon, avoiding only those areas where height would increase the danger of the paint dripping from the brush onto her hand.

One of the ward attendants from the disturbed ward brought another patient over with him. He carefully showed Dick how to handle the paint roller, how to fill it, how to roll it and worked with Dick till he felt sure Dick knew how to use the roller, and then he took another roller himself and joined the painting. The attendant was a very good painter and worked with complete absorption in his work the entire time he was there, doing an entire wall himself. However, the occupational therapist noticed that as soon as the attendant left him, Dick started slowing down. Within a few moments he was pushing the roller back and forth over the same spot mechanically. She moved over and worked beside him, encouraging him at times, helping him fill his roller each time and talking to him as they both worked.

The therapist herself continued to paint until she no-

*The italics are added.

ticed a sixth patient, Robin, arriving. All four rollers were in use and she felt that Robin would feel uncomfortable and would refuse if she offered him her roller directly; therefore, "quite naturally" she put the roller down and began cleaning up areas of dripped paint on the floor. Robin came in, saw that one paint roller was available, and immediately joined the group painting.

Four hours and numerous similar incidents later the painting was finished. In the course of the afternoon about 10 patients and two or three personnel worked on the project and in addition several other patients and personnel wandered through, stopped to kibitz, or just watched.

The activity therapist occupies a changing role vis-a-vis his patients and must have the ability and the freedom to vary his role from leader to participant to a mere observer. In the shop or clinic situation he is frequently faced with the problem of a number of patients, each working on individual projects, each needing his time and attention, each needing his assistance or support. He must be constantly aware of how the performance capacity of each individual patient is influenced by group interactions. Each patient's motivational level, too, must be monitored constantly by the therapist, since the motivations of disturbed patients to participate in activities are subject to sudden shifts under the influence of events which in any other group would not change motivations. Because both performance and motivation may change momentarily, the timing of his decisions and of his responses is of utmost importance. He must assume responsibility at one moment and be ready and willing to relinquish it to a patient at the next. He must move in here, step back there, like a dancer in an unrehearsed dance, taking his cues from the patients much as a dancer would from the music and from the other dancers.

The therapist is also quite frequently in the position of having to mediate between the conflicting needs of the group and of an individual. During certain episodes the therapist has found himself having to sacrifice the participation of such a patient as Dick, with his need for a great deal of support, to the needs of the group as a whole. For example, during a play production one of the patients, who could not learn his lines, had to be shifted late in the rehearsals from a speaking part into a small part which did not involve important entrances or exits or any lines. This intervention was necessary in order to accomplish the group goal of high level production even though the patient was unusually embarrassed because he had been a professional actor before he became ill.

Many factors undoubtedly influence the quality and quantity of a patient's participation in occupational therapy. Activities occurring together, which psychologically complement each other, may create a group situation where the enthusiasm of a few spreads and enhances the involvement power of adjacent situations. The enthusiasm of a single person may have a contagious effect on others who at first are immobilized by ambivalence or conflicting desires both to participate and to avoid. A structured situation which helps the patient to perceive clearly what is going on and where he fits in may enable him more easily to become involved. The occupational therapist must be aware of and ready to capitalize on these natural forces latent in any activity situation.

An analysis of the role of the occupational therapist in another episode will further illustrate the complexity of the job at hand.

The patient group wanted to do a variety show. Since the group had just completed a very ambitious full length production, the therapist felt no need to push the group to activity. He felt that they should only do the show if they really wanted to. (This contrasts with the more usual situation in which the therapist's goal is to foster desire and interest in the activity.) During the actual preparation of the show he was hopeful that the patients would be able to take more leadership than they were actually able to take.

In analyzing what the therapist *did* in response to this situation, his activity was seen to fall into three phases. During the first phase he spent some time *clarifying* the perception in the patients' minds of what a variety show, in general, consists of and what kind of effort it would entail. This helped the patients to decide whether or not they wanted to go ahead with the plan. For example, at the first group meeting he made clear when the show could be scheduled, roughly which patients would be able to participate, and the general type of show which it was possible to arrange at this time. He also made clear that the specific acts and the general idea to be dramatized would be an open question to be worked out during rehearsals.

A second phase then began during which the therapist *waited* in order to test the patients' motivation for the plan which had been clarified. During this time the therapist continued to make known his availability as a leader and to "wait and see" how the patients responded. When only one patient appeared at a second scheduled meeting, he was ready to drop the whole idea. Then unexpectedly, one after another, the members of the original group returned, requesting some action.

The third phase then began. It consisted of the provision of minimum necessary *leadership* to the patients during the rehearsals and during the show itself. Here the therapist carried out a number of functions. He urged each patient to prepare his own part for the show without any direction; when all but one of the patients were unable to be self-directed, he provided the structure (a radio script) and the original ideas (song and skit suggestions) for each of the patients. After the rehearsals began he had not only to support the timid performers but also to set limits to the over-enthusiastic ones in order that the show might continue to give satisfaction to the total group. Finally, quite a number of functions which had to be carried out in order to produce the show (typing, lights, etc.) he decided to do

himself because the needed motivations and skills did not emerge from the group. He felt this was preferable to resorting to too much pressure on the patients.

In all of these episodes the occupational therapist was working with the permission and the collaboration of the psychiatrists. In the painting project the administrative doctor and occupational therapist were both present at the patients' meeting where the plan was originated and discussed. Then they discussed the project and the individual patient participants in several informal discussions before, during and after the project. Both of them conceived of this project as one small but important part of the activity program for the ward group and for each individual patient. In cases where the occupational therapist had time to consider a difficult decision regarding a particular patient—such as shifting the patient to a non-speaking part in the play production—he consulted the patient's doctor and discussed with him the best way to handle the situation. However, he alone was in the position of deciding what was best for the group. The doctor could only help the therapist, through his knowledge of the patient, to handle this necessary shift of play roles in the least traumatic way. The variety show episode, in general, proved to be a positive, enjoyable experience for the twelve patients who took part. For one of the twelve, however, it proved to be a challenging growth experience. The behavior of this patient throughout rehearsals was erratic and volcanic in nature and the occupational therapist repeatedly had found difficulty in handling this individual's upsets without detriment to the group. In the beginning the patient's reactions were so unpredictable and so changeable that no "course of action" or "attitude" could be decided upon and stuck to. Different approaches had to be tried and discarded. Throughout the rehearsals the occupational therapist held several discussions with the patient's psychiatrist in which the doctor contributed historical information and impressions about the patient and the occupational therapist contributed observations made while participating with the patient in action. By means of these collaborative conferences the patient was helped to meet the interpersonal challenges of the variety show.

Such observations as these have confirmed the impression that program planning for psychiatric patients is too complex to be prescribed. The therapist must plan, of course, but in a manner which utilizes his knowledge of the patient gained from the doctor, from other staff members and from his own past and present experiences. He must not be bound by the inevitable rigidity of a prescribed plan.

CONCEPTS TO GUIDE PSYCHIATRIC OCCUPATIONAL THERAPY

The multiplicity of issues which may be involved in providing an emotionally hygienic environment for disturbed patients is surely clear. Adequate performance in the face of this shifting maze of potentially therapeutic or anti-therapeutic influences demands a differentiated conceptual frame of reference for milieu therapy. Such an organized set of concepts should define realistic goals, goals which are attainable with occupational therapy techniques and goals which are understandably related to the work of the other members of the psychiatric team. We agree with Azima and Wittkower's characterization of the field as suffering from a "concept-deficiency disease."[1]

Fortunately there are signs that remedies are now being prepared to deal with this "disease" in the form of recent theoretical papers and research studies.[1,11,13] For example, Azima and Wittkower state that the rationale for creative art therapy is an adjunct to psychotherapy to uncover drives, defences and transference phenomena. One may follow or not follow this concept of occupational therapy, depending upon the treatment philosophy of a given hospital; at least, phrased in this way, art work takes on a meaningful relationship to other therapeutic processes. These authors also believe that current occupational therapy theory over-emphasizes "the strengthening of the ego's defences of suppression and denial" and under-emphasizes work which challenges the patient's "emerging autonomous ego reorganization." With this we would agree, but also point out that concepts are needed to guide the therapist and to define when impulse-suppressing activities are indicated as opposed to impulse-stimulating activities. In a recent study[14] of concepts implicitly used by staff members in a residential treatment center, Goodrich and Boomer found that at times when the the patients seemed extremely tense or on the edge of anger, the staff employed highly structured games with strict rules to guide players' actions. At other times when patients seemed "bottled up," restless or bored, vigorous or loud games which promote free impulse expression were encouraged. Thus the concept of the patient's momentary behavioral state, or ego state, became important in determining the type of therapeutic intervention. More systematic concepts are needed to classify patients' momentary ego states and to define milieu therapy techniques in relation to these shifting patient states. The simple procedure of (A) collecting descriptive episodes of patient-staff involvement, (B) discussing each episode at length to clarify the

issues involved, and (C) classifying those concepts which emerge, seems an appropriate exploratory method[2,14] for making progress toward a more differentiated theory of milieu therapy.

SUMMARY

The concerns which have led us to this discussion in psychiatric occupational therapy are similar to those concerns expressed recently by Azima and Wittkower[1] when they refer to the "weakness of liaison between the occupational therapist and the psychiatrist" and to the "lack of a theory of occupational therapy."

We believe that occupational therapists, or other participant therapists, have a unique contribution to make to psychiatric diagnosis and treatment by virtue of their participant role in the lives of patients. Today the worker in this area is faced with a large number of as yet ill-defined concepts about activities, social situations, patients' motivations, and therapeutic relationships. The work is concerned with the contagiousness of emotions and attitudes in a group. It is concerned with communication and decision-making structures in a patient group and in the hospital as a whole. It is concerned with the impact of various group situations upon the ego strength and ego growth of disturbed patients.

The procedure of a physician writing a relatively brief written order to guide this work has been based on the concept that the occupatoinal therapist functions in a static situation toward goals which can be very specifically defined in advance. Growing experience of many workers in many hospitals has demonstrated that a more realistic concept of occupational therapy is one in which the therapist makes a broad, flexible contribution to the patient's life in the hospital and performs a great variety of therapeutic roles. We most emphatically disagree with the proposition that the complexities of the patient's problems and the complexities of the therapeutic milieu can be dealt with in brief form. Reliance on the doctor's prescription has had a tendency to keep occupational therapists limited to a shop situation where the patient comes in for an hour or two each day, where the situation is highly structured for the therapist and the patient, and therefore where the need for spontaneous decisions on the part of the therapist are kept to a minimum. It has had a tendency to prevent occupational therapists from working with groups because, weighted down with specific orders for each patient, he is limited in his ability to deal with this entity, "the group," for which he has no prescription. Also, it has had a tendency to confine the occupational therapist's role to that of "technical assistant"[5] and thereby to limit potentialities for professional growth and to prevent full recognition of the therapeutic responsibilities of the occupational therapist within the psychiatric hospital mileu.

Recent studies[1,2,11,14] have suggested that, while a knowledge of psychoanalytic and social science theory is helpful, basically what is needed is a more highly differentiated set of concepts adapted specifically to the situation in which the occupational therapist finds himself. These concepts are needed to define the therapeutic properties of activities and the therapeutic issues in the international milieu of a treatment situation.

BIBLIOGRAPHY

1. Azima, H., and Wittkower, E. D. "A Partial Field Survey of Psychiatric Occupational Therapy," *AJOT*, 11: 1-7, (January-February) 1957.

2. Goodrich, D. Wells; Mazer, J. L., and Cline, B. "Problems of Fostering Psychiatric Patients' Involvement in Activities," *Psychiatry*, (In Press).

3. *Webster's New Collegiate Dictionary*. Springfield, Mass.: G. & C. Merriam Co., 1956.

4. *New Gould Medical Dictionary*. Blackiston Division, McGraw Hill Book Company, 2nd Edition, 1956.

5. Dunton, Wm. Rush, Jr. *Prescribing Occupational Therapy*. Illinois: Charles C. Thomas, 2nd Edition, 1947.

6. Barton, Walter E. "Medical Supervision in Occupational Therapy," *AJOT* 9: 53-56 (March-April) 1955.

7. Fidler, G. S. and Fidler, J. W. *Introduction to Psychiatric Occupational Therapy*. New York: Macmillan Co., 1954, p. 62.

8. Mimeographed material AOTA conference supported by National Office of Vocational Rehabilitation, Allenberry Inn, Boiling Springs, Pa., November, 1956.

9. Vellani, Sonia T. "The Role of an Initial Interview in Integrating the Rehabilitation Services of a Neuropsychiatric Hospital," *AJOT*, 11: 71-72, 88, (March-April) 1957.

10. Elkins, H. K., Van Vlack, N. M., and Marcil, S. E. "Prescribing and Attaining Pre-determined Goals —Neuropsychiatry," *AJOT*, 10: 235-236, 1956.

11. Huntting, I., and Semrad, E. V. "More Specific Prescribing of Occupational Therapy," *AJOT*, 6: 262-264, 1952.

12. Neubauer, P. B. and Beller, E. K. "Differential Contributions of the Educator and Clinician to the Diagnosis of the Pre-Latency Child," *Amer. J. of Orthopsychiatry*, (In Press, 1957)

13. Redl, F. and Wineman, D. *Controls from Within*. Glencoe, Illinois: The Free Press, 1952.

14. Goodrich, D. Wells and Boomer, D. S. "Some Concepts About Therapeutic Intervention With Hyperaggressive Children," (In Press).

REPRINTS

Reprints are convenient for teaching files in hospitals. If you would like a few copies of articles appearing in this issue, your order will be honored if enough requests from others are received to total the minimum order of 50 for an article. Place your orders before the 25th of the month of publication.

THE FINGER EXTENSION MECHANISM

O. LEONARD HUDDLESTON, M.D., Ph.D.[1]
WILLIAM HENDERSON[2]
JOHN W. CAMPBELL, O.T.R.[3]

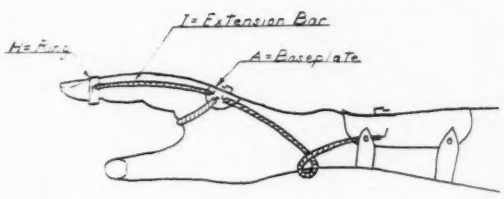


Figure 1. Diagram showing construction of finger extension mechanisms which are easily attached to a basic wrist splint.

This is the fourth in a series of articles on braces developed at the California Rehabilitation Center.[4] The four articles were presented together so that their relationship to each other could be described more clearly.

The finger extension mechanisms are presented last so that it can be shown how they may be applied to any of the three preceding braces. It should be stressed that many of the parts of one brace are common to the other braces so that conversion from one type to another, or addition of one mechanism to any one brace can be accomplished quite readily. This allows for improvement in the patient. The finger extension mechanism, for example, can also be added when necessary, and taken off when finger extension has improved..

OBJECTIVE

The objective of the finger extension mechanism is to provide passive finger extension which will simulate normal hand position as closely as possible, and not extend beyond the hand thus causing obstruction or objectionable appearance.

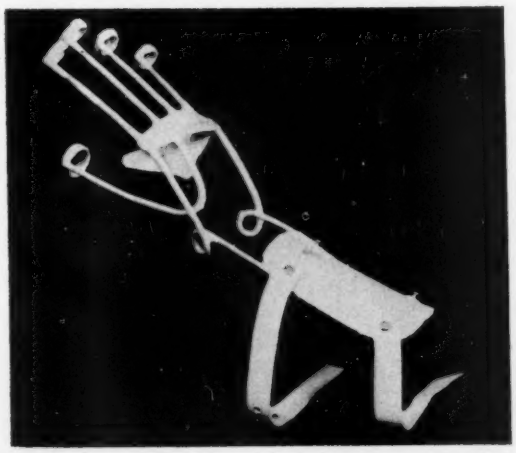


Figure 2. Finger extension mechanisms for second, third, fourth and fifth fingers attached to base plate of functional wrist splint. Opponens attachment also fastened to base plate.

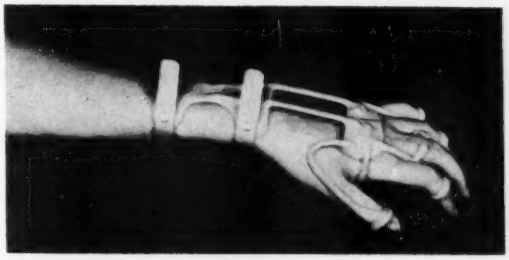


Figure 3. Photograph showing finger extension mechanism and opponens attachment to base plate of static extension splint. The splint is applied to forearm, wrist and hand of a patient who has had polio.

DESCRIPTION

The finger extension mechanism, shown in Figure I extends the fingers by means of an extension bar (I) which is attached to the base plate (A) of a brace. From the base plate, the bar runs along the radial side of the finger just beyond the joint of the finger which lacks extension. A ring is soldered to the extension bar and holds the finger in place. The extension bar provides the spring action for returning the finger to the extended position.

CONSTRUCTION

First determine at which joint active extension is lacking; then the amount of extension power required in the bar to extend each individual finger. When it has been determined which joint lacks active extension, the amount of power required in the bar may be tested very simply. Take a piece of cable housing four inches long and tape one end to the finger just beyond the joint to be extended. Then run a very light piece of piano wire through the cable housing and hold the other end of the wire and cable housing to the base plate. If

(*Continued on page* 187)

1. The medical director of the California Rehabilitation Center.

2. Formerly upper extremity prosthetist at the California Rehabilitation Center. Presently research engineer, artificial limbs project, University of California at Los Angeles, California.

3. Director of occupational therapy department of the California Rehabilitation Center, Santa Monica, California.

4. The other articles appeared in the previous three issues of the American Journal of Occupational Therapy.

PSYCHOLOGICAL ASPECTS OF ACTIVITY FOR THE AGED

MARTIN LAKIN, Ph.D.[1]

MELVIN DRAY[2]

Therapeutic work activity for aged individuals who are residents in homes for the aged presents a unique problem to those concerned with the institutional care of such persons. This paper presents experiences and observations arising from one exploratory approach to this problem.

BACKGROUND

The progressive home for the aged usually acts upon the assumption that activity is inherently therapeutic for the resident and that inactivity hastens debilitative and deterioration processes. This assumption, while far from novel in rehabilitative work, has only recently been given an experimentally validated basis.[1] Ideally, the aging individual in a progressive institutional setting is encouraged to participate in a variety of recreational, social and religious activities. In this institution special provisions and adaptations are made so that even the bed-ridden and infirm may be as active as their physical and mental limitations permit.

We feel that insufficient attention is paid to the attitude of the aged individual toward the activity in which he may be encouraged to participate. Conviction that activity is "somehow good" seems to be insufficient as a basis for programing. We feel that it is most important to try to understand the individual's feelings about the activity, to look upon it, as it were, with his eyes, to follow his understanding of its purposes, and to try to gauge its effects, both positive and negative, upon his view of himself (self-image).

In order to gain the requisite insight about the factors outlined above, we undertook to interview residents about one important phase of activities in this institution—the "hobby shop" sector of the occupational therapy program. We asked individuals who participated in it on a fairly active basis, as well as those who chose to avoid it, to discuss with us their feelings about the activity and their reasons for participation or non-participation. We were also concerned with their attitudes toward work in general and their feelings about themselves in relation to work.

Somewhat to our surprise, we found that those who participated fairly actively, as well as those who did not, derogated the activity. Anything connected with arts and crafts (the major "work" in the shop) was termed "foolishness" by a majority of the respondents. It is significant that individuals who did not participate and who designated the activity as "childish" or as "nonsense" gave rather thin rationalizations for their non-participation such as "My hands shake too much for that sort of thing," "I can't see well enough," or simply, "I'm too old for that sort of thing."

Deeper inquiry in the cases of those who did not participate frequently revealed a basic pattern of concern about the meaning of participation in terms of their own view of themselves. The following case may illustrate this problem in terms of the discrepancy between the view of the work and the self-image. A 71-year-old resident had always worked as a laborer. He had apparently always prided himself on his physical prowess, and strove to maintain a view of himself as physically powerful. He said, "That work down there is for babies; it's not real work. I like real work." The inference is compelling. This individual saw in the arts and crafts program an obvious infantilizing activity which defined him as a helplessly invalided and weak person.

The attitudes of those who did participate toward their products were particularly illuminating. Inquiry about the items produced (small pieces of jewelry, ash trays, ceramics, etc.) was frequently met by embarrassed laughter. In response to questioning about an obviously well-made pair of enameled earrings, one individual remarked, "That's all I'm good for now, just to sit here and make this kind of stuff." Another individual making ceramic pieces complained, "In my old age I should sit and play with clay." It seemed to us that fears about prestige and status loss among the aged were not only unalleviated by these types of activity, but were even reinforced by the resident's attitude toward their significance.

What about those who experienced satisfaction in their hobby shop work? This group consisted largely of females and their activities were of the sewing, knitting and crocheting variety.

1. Department of neurology and psychiatry, Northwestern University Medical School; consultant to the Orthodox Jewish Home for the Aged, BMZ, and VA Research Hospital, Chicago, Ill.

2. Assistant director, Orthodox Jewish Home for the Aged, BMZ, Chicago, Illinois.

It seemed to us that their contentment lay in the fact that these activities were those in which they had indulged for many, many years, perhaps the greater part of their lives. Here there could be no diminution in self-image as a consequence of the activity. On the contrary, their continued activity in these areas served as reassurance that they had retained significant degrees of their former skills and capacities. It need hardly be added that little encouragement was necessary to get them to continue this work.

From our review of the attitudes toward work and toward work activity among the aged residents of this institution and from our survey of studies of activity significance among the aged[3] we have come to accept the following postulates:

1. For the institutionalized aged, a plan of work-involved activities must consider relevant social-psychological and individual psychological factors.

2. For the aged person, no less than for the younger individual, work-activity programs are a vehicle for self expression and provide a mirror for the reflection of self worth and esteem.

3. A work activity which is aesthetically satisfying and creative for one individual may, for reason of difference in background and in personality, be self demeaning to another. This divergence in view, usually commonly accepted for younger individuals, gains greater significance here because of the relatively greater inflexibility of views of self among the aged.

Social-psychological factors involved consideration of the common background of the residents of this home. They were all of Eastern European background and had extremely limited exposure to formal school (most of the males had studied in the Cheder, the Jewish parochial school; most of the females had had no education at all.) All had experienced some degree of emotional and physical privation either in Europe or in this country or both. They had worked in semi-skilled trades or in extremely modest business enterprises for the most part. Cultural or leisure time pursuits were quite uncommon (except for activities concerned with Synagogue attendance) and the possession of any kind of technical skill was a rarity among them. For the group as a whole, work for which one is paid is worthwhile activity. We were impressed by the alacrity with which these individuals would register their high regard for a "wage-earner"—he is one who is "worth something." In this feeling, of course, they were accurately reflecting societal values. The individual who can earn is the one who may retain status in our culture (Linton). The one who no longer can do so frequently accurately reflects society's judgment that he is "all washed up" and no longer a worthwhile person.

We began to ask ourselves whether the reestablishment of a situation in which these individuals could once more resume "wage-earning" activities would aid in retention of a view of self as a worth-while person. We wondered further whether these aged institutionalized individuals would be able to effectively participate in a work program which could be a legitimate wage-earning medium and not just charitable busy work. These are examples of the questions which arose as a consequence of our findings from interviews with the individuals. We concluded that our basic aim must be to provide or to seek out activity which would reinforce the positive elements in the otherwise shrinking self-images of the institutionalized aged. With this aim, we began a sheltered workshop as our experimental approach to the problem of work activity for the aged.

SHELTERED WORKSHOP PROGRAM

In establishing the program the following principles were evolved and served as the basis of operation:

1. Types of work which could be effectively accomplished by aging and infirm individuals were selected. These were evaluated upon the basis of consideration of the requirements of vision, manual dexterity, postural strain, etc. Projects were reviewed by the psychologist and by the assistant director as well as by vocational counseling consultants from a cooperative agency, the Jewish Vocational Service.

2. A work atmosphere was created. Participating residents were impressed with the need for following instructions, obeying rules, and maintaining standards of quality. Only those who felt they could adjust themselves to these minimal demands were included in the projects.

3. A limit of 4 hours per day (2 in the morning and 2 in the afternoon) 4 days per week was set so as to provide a continuous though non-taxing schedule and to allow sufficient time and opportunity for participation in the various other phases of the social and cultural program of the home. Participation was on a voluntary basis and the resident could work as many hours as he wished within the limits imposed. Pay was on the basis of hours worked.

4. Payment was at a fixed hourly rate for all residents. No incentives or bonuses were offered because we did not wish to involve the residents in "sponsored" competition with one another. Residents whose production failed to meet a minimum rate were given other work on other projects or were excluded.

PILOT PROJECTS

1. Wand bundle assembly: Plastic wands, coupled commercially with bubble blowing liquids, are taken from piles and banded. No counting is involved. A handful is gathered and the only inspection required is simply to see that they are turned in a uniform direction. None of the residents who participated (including several markedly senile individuals) had difficulty in meeting the set minimum of 1,000 per hour.

2. Comb-hairpin assembly: Four hairpins are inserted in slots on a comb at right angles to the teeth. The combs do not have to be counted nor is great care required in packaging. A minimum rate of 120 finished combs per hour has been set and is well within the abilities range of the average participant.

3. Display ribbon bows. The operations involved are as follows: Four lengths of ribbon are simultaneously cut on an especially designed device. Another uncomplicated device is used to hold them in place while bows are tied and fixed in place with wire. Completed displays are packed according to a designated pattern. (This task requires considerable alertness, more manual dexterity, greater visual acuity and stamina than do the preceding tasks. For this reason, participation has been limited to the more capable among the residents.)

4. Display cards. The project involves a series of simple operations: (a) affixing a tube of glue to a display card; (b) affixing six bottles of "glitter," each of a different color, to the card; (c) inspection, counting and packaging according to instructions.

The above list does not describe all the projects attempted nor those under consideration for future implementation. Some are slightly more ambitious and make somewhat greater demands upon the resident. In the main, however, they are sedentary in nature, do not require great accuracy, and demand minimal sensory-motor integration and hand-eye coordination. The contracts are undertaken by the institution with the therapeutic aim as primary. The service is, of course, important to the contracting firm. Profits are paid out in wages to the residents who do the work. The resident can make any use he wishes of the monies he earns in this way. Psychomotor characteristics of these projects are chiefly routinized and stereotyped movements of the hands. Speed of response is largely non-significant. This latter point is most important because of marked limitation of the aged in speed of response. The stereotyped quality of repetitive movement offers no disadvantage inasmuch as simple perseverative routine is frequently reflected in performances by the very old on psychological visual-motor tests.[2]

OBSERVATIONS

Wage earning activity in a structured group situation is the primary therapeutic vehicle. After approximately one year of experimentation we are able to record certain impressions and to indicate lines of development for further study.

1. Group morale, of little account in arts and crafts activities, has emerged as a significant factor in the sheltered workshop. The results have been especially interesting in terms of work atmosphere. The residents have, in a sense, recreated a social-emotional atmosphere reminiscent of the old-time workshops of their early immigrant days. They have even resuscitated the terminology of that period, preferring to designate the supervising staff individual as the "floor-lady" and the individual who bears major responsibility for the projects and pay as the "boss." Gossiping across the table, positive as well as negative comments across the room about each other, and competitive challenges as to rate or quality of work are currently part of the charged atmosphere of the sheltered workshop. In fact, group elan has appeared where previously few signs of group "belongingness" were evidenced. The interpersonal and group tempo and atmosphere of the workshop contrast directly with individual withdrawal and social isolation which frequently characterize other aspects of a home for the aged. Social isolation has been replaced by fairly vigorous interpersonal experience in the structure of the work situation.

2. The wage, although minimal by current standards, is obviously a source of considerable gratification to virtually all the participants. Aside from its immediate utility (these individuals have meager funds and the monies earned in this fashion may be used to supplement the small monthly allowance), the earner retrieves at least a shadow of the former feeling of productiveness. It is not mere happenstance that these old people recreate the atmosphere of the "shop." It is an entirely volitional phenomenon and furthermore, an expression of the need to feel that they can, even with withered limbs and assorted bodily impairments, produce a product someone wants and needs. It may express, from this point of view, a sense of the tangibleness of their own existence, and an assertion of their own wish to continue to exist.

3. It is possible that the continued practice of innate and acquired psychomotor skill may help retain function in certain areas and may thus help to delay deteriorative processes. At the present time, this hypothesis is speculative and will require extensive study. Certainly, this is a vital area for research, especially in view of its possible significance for general understanding of relationships between activity and deterioration in aging.

THE INDIVIDUAL RESPONSE

Experimentation with a sheltered workshop approach did not have as its central aim resolution of the variegated problems of self concept among institutionalized aged. Their difficulties are multiple and no one type of activity can modify basic personality structure or a life-long pattern of habitual response to interpersonal situations. In the preceding discussion, we have focused upon perceptible changes in group behavior. We have noted that individuals "seemed" happier; we have inferred that they felt better about themselves as a consequence of their participation in the workshop program. However, it is also important that we focus upon the individual directly, his problems and motivation in terms of his participation and the effects of the program upon him.

Manageability was the pressing problem from the point of view of the staff in the case of one senile woman who had the delusion that her sister (long dead) was still alive. She would rush from the home in frenzied attempts to rejoin her because she had to "go to care for my sister." On the basis of the psychologist's observation that she was delighted by the simple perseverative motor acts on one of the psychological tests, it was speculated that being engaged in similar psychomotor activity might involve her and perhaps even decrease the pressure of emotional tensions. This lady responded to a work role and even revised her delusion to fit her more positive attitude; now she was employed in the "shop" and *earning* money which she could send to the needy sister. Here, obviously, no changes in personality structure nor in psychopathology were effected. However, there was a significant alteration in mood, a shift in

the direction of compliance. She had been previously described as senile and psychotic and she remained senile and psychotic, but the work role and its meanings for her were sufficiently potent so as to alleviate the otherwise intolerable burden of management.

A second case illustrates what we have chosen to think of as the retardation of social withdrawal. An individual had not participated in social functions because of "difficulty in walking." This handicap provided, in reality, a rationalization for non-participation which had characterized her total adjustment to communal and social life in the home. It was considered something of a minor miracle when this individual appeared under her own power and announced that she "had come to work." It was clear that the incentive of the wage was the significant motivating factor in this case. Status as a grandmother who could afford to buy presents for her grandchildren with money she had *earned* was a powerful motivating factor. Only incidentally, so far as she was concerned, did increased social and interpersonal contact result. Nevertheless, the fact that it did was held to be a significant gain in terms of this individual's total adjustment.

The effects of increased social contact are not invariably salutory in a home for the aged. There are those individuals whom it is advisable to limit in terms of their exposure to others. Mr. R's case, that of an individual with fairly active paranoid tendencies, illustrates the need for due consideration of personality factors prior to encouraging participation in a program of this kind. This individual was very quick to join the project; however, shortly thereafter, he began to try to dominate the others by overt manifestations of competitiveness toward physically less adequate individuals. He clearly tried to dominate the group and seemed frightened that, unless he succeeded in doing so, they would unite against him. He failed to achieve his purpose and, at least in some measure, his fear was realized. Finally he announced that inasmuch as he was being paid too little, he would quit. We speculated that increased exposure to interpersonal contact may have exacerbated the difficulties of Mr. R, who was known to have rather intense problems in these areas and who had never gotten along well in group situations.

Personality difficulties were likewise a primary factor in Mr. L's withdrawal from the workshop. That a female supervisor or "floor lady" should tell him what to do and how to do it was a severe affront to this individual. His shredded concept of his own masculinity was such that each new direction or instruction was an indignity. He withdrew on several occasions following these "insults" and eventually stopped working. It is interesting that he continues to hover about the workshop during activity hours, making rather feeble gibes at the others who continue to work. He claims he is on "vacation" and repeatedly requests "vacation pay." It is clear, however, that he derived very considerable gratification from the activity itself, would have preferred to continue, and enjoyed viewing himself as a "worker."

A somewhat happier resolution of the interpersonal problem is illustrated by the case of yet another resident. He was guarded toward others and had been viewed by staff personnel as somewhat misanthropic, but without active paranoid tendencies. He was an individual who kept to himself and avoided intimate relationships with the other residents. He was invited to join the project but the staff had considerable reservation about his adjustability. Characteristically, he selected a phase of one of the operations which necessitated his keeping his back turned upon the work tables and which minimized the interpersonal element. We noted some slight change in the direction of acknowledgment of the presence of the others; even occasional greetings were exchanged. He remains taciturn but will report to work regularly and eagerly. Upon being questioned about his participation, he responds that this is a good way to "kill time," that he feels better when he is active in "doing something to kill time."

The cases described above illustrate two central aspects of the sheltered workshop program in a home for the aged. One is the mainly positive alterations in mood and in self valuation resultant from participation in the program. The other is the importance of consideration of certain relevant personality factors in the individual prior to selection for participation. Projects may be carefully selected on the basis of psychomotor limitations of the population involved. Working hours, pay rate, physical circumstances may all be conveniently arranged. However, three basic questions should be considered before encouraging the individual to participate.

1. Can the individual accept even minimal supervision?
2. Can he relate, in some minimal way at least, to the group?
3. Are his psychomotor abilities equal to even such modest requirements as have been illustrated in the projects described above?

If the answers to these questions are affirmative, the individual might be expected to profit from the workshop experience.

Provided that these questions may be answered in the affirmative for at least a major sector of the aged individuals in an institutional or quasi-institutional setting under consideration, the shel-

(*Continued on page* 187)

WORK THERAPY IN AN ARMY HOSPITAL

HELEN SHEEHAN, Major, AMSC[1]
BARBARA VIESKO, Lt., AMSC[2]

An experimental work therapy program was initiated several months ago for neuropsychiatric patients at Letterman Army Hospital. The results of this program are being discussed in this paper. As conducted in this hospital, the program might well be described as an attempt at therapeutic placement of neuropsychiatric patients in supervised hospital job assignments.

The purposes for which this program was established were many. For the medical staff it was hoped that it might (1) assist in determining medical disposition, on the basis of on-the-job performance, (2) support or disprove previous reports of a given patient's inadequacy in performance of duty, and (3) aid the medical staff in determining the effectiveness of the patient's treatment program.

For the individual patient, the long range purposes are (1) to assist in the transition from a protected to an independent environment, (2) to help re-establish self confidence, (3) to restore a sense of responsibility, (4) to fulfill a need for being a useful member of the group, (5) to rebuild morale and (6) to channel energy into constructive patterns of productivity. In addition this program concerns the service which these patients might render to the hospital staff as (1) temporary assistance when adequate numbers of assigned personnel are not available, and (2) as an aid in routine projects, thereby releasing trained personnel for more technical duties.

Each patient who is to be considered a candidate for the work therapy program must already be participating in occupational therapy. It has been felt that the occupational therapist, through observation of the patient in the occupational therapy clinic, is able to provide the medical officer with valuable assistance as well as an evaluation of the patient's capabilities and work habits. The occupational therapist is able to observe the patient's work habits, socialization and adjustment in the clinic. Also, knowing the job descriptions, as well as the job supervisors, she is better able to select a good working environment for the patient.

Recommendation and/or selection of a patient for work therapy may be initiated as verbal request from the doctor to the therapist to afford an opportunity for mutual discussion of the case, as a request from the occupational therapist to the doctor, or as a request from the patient himself, either to his doctor or to the therapist.

Upon approval of the request, the occupational therapist acts as the liaison between the doctor, the patient and the hospital staff personnel for a particular job placement. The therapist interviews the patient, discusses his previous work experiences, his military occupational specialty and possible interests. Also considered is the patient's reactions to the job, his mannerisms, personality traits and his possible behavior in relation to the specific assignment and/or job supervisor concerned.

When an assignment has been selected, the job supervisor is contacted and an appointment is arranged. At this appointment, the occupational therapist introduces the patient to the supervisor, and a mutually agreeable reporting time is decided upon. The neuropsychiatric nursing service is then notified, so that the patient may be relieved of ward assignments and his ground privilege card issued. The doctor is also notified of the patient's job assignment.

Before reporting to his job, the patient is made aware of his responsibility to keep his job supervisor informed of any appointments, medical or otherwise, which will necessitate his absence. He is also informed of the consequences of his failure in this respect, i.e., that an absence constitutes being "AWOL," a fact which has a marked impression on the patient.

The patient's work is always scheduled to permit his attendance at group therapy sessions, ward rounds and to allow for necessary appointments. When the patient wishes, he is also allowed to return to the occupational therapy clinic daily, at a scheduled time, to complete any unfinished project.

The occupational therapist contacts both the job supervisor and the patient, at regular intervals, to observe and evaluate the patient's performance. Progress notes are sent to the doctor, based on these appraisals.

SUMMARY

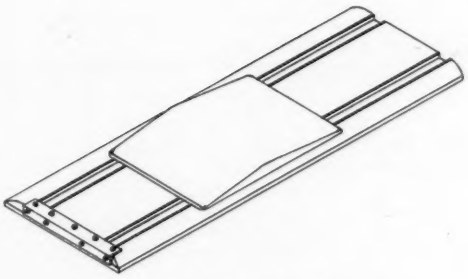
The results of this program to date may be summarized as follows:

1. It provides for the patient on the neuropsychiatric service, especially on the closed wards, new interests and contacts with personnel and areas of the hospital other than those with which he may have been closely associated for long periods of time.

(*Continued on page* 188)

1. Chief occupational therapist, Letterman Army Hospital, San Francisco, California.
2. Psychiatric occupational therapist, Letterman Army Hospital, San Francisco, California.

CASTER SLIDING BOARD*



Caster Sliding Board

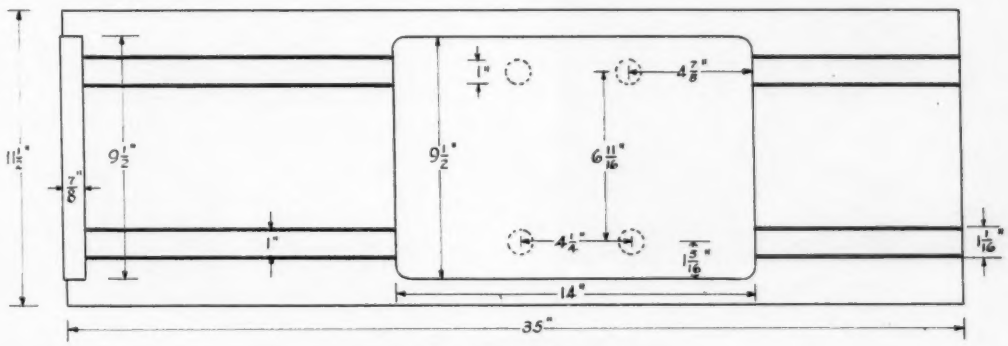
End View of Caster Sliding Board

The caster sliding board was devised as another method to ease transfer of a severely paralyzed patient from wheelchair to car and vice versa. It is particularly effective for the patient with little or no power in the legs and hips, a weak trunk, and insufficient power in one or both arms, particularly in the shoulders, to pull himself into the car by means of the conventional sliding board. This method puts little strain on the person assisting and enables a smaller or less muscular person to assist a paralyzed person into a car with a minimum of effort from either party—rather letting the action of the casters on the board do most of the work, and requiring no lifting by the person assisting. This minimizes the possibility of back strain, and also increases the number of persons who are able to assist the patient. In certain instances this method may replace the need for a car lift.

The caster sliding board consists of a small board placed on top of a larger board. The small board, on which the patient is seated, glides along on two tracks which run lengthwise in the larger board. The patient's wheelchair is lined up beside the opened car door on the side he wishes to enter, usually the passenger's side of the front seat. The wheelchair should be as close to the side of the car and as far forward toward the inside of the opened car door as possible. The person assisting sits on the front seat, on the side where the patient will eventually sit. The left arm rest is removed from the wheelchair. The larger board bridges the gap between the car seat and the wheelchair seat, leaving enough of the board on both seats to make it secure.

The smaller board (with casters, and beveled at each end) is slid along the track until it hits the "stop" on the patient's side, and is pushed under the patient's buttocks. If the patient is able to assist at all he pushes himself or scoots to the middle to the small board; if not, the assisting person pulls him onto the board. It is well for the assisting person to hold down the end of the small board at his end so that the casters do not come out of the tracks. When the patient is seated in the center of the small board, the person assisting puts his right arm around the waist of the patient. If the patient's trunk balance is weak, the patient's left arm is placed around the shoulders or neck of the person assisting. In this fashion, sitting side by side on the larger sliding board, the assisting person merely pulls the patient along with him as he scoots sideways back into the car seat. At the appropriate point in the transfer the as-

(*Continued on page* 189)



Top View of Complete Sliding Board

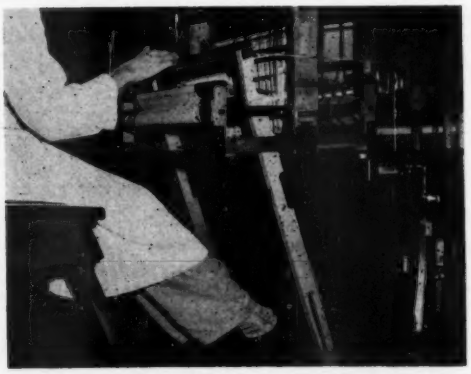
*Devised by the occupational therapy department, Fairmount Hospital, San Leandro, California.

Picture Page

Weaving Adaptations

Boat shuttle adapted for patients with disabilities involving grasp and/or incoordination resulting from causes such as cerebral vascular accidents and brachial plexus injuries.

Closeup of regular size boat shuttle and adapted boat shuttle.



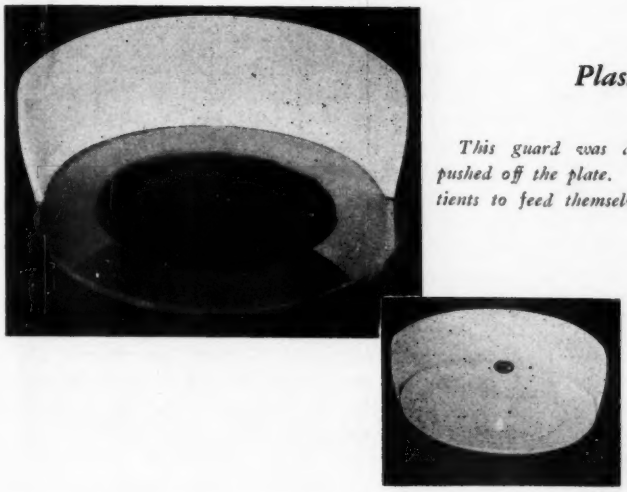
A Structo table loom with quadriceps adaptation attached to an adjustable overbed table. Side frames of beater were replaced with long frames which barely clear the floor and which are connected by a footrest between the two extensions. One side of each extension was cut away to permit the beater to move its normal range. Resistance to knee extension is given by the pulley system.

Above Pictures submitted by National Navy Medical Center, Bethesda, Md.

This shuttle rest for a Peacock loom was designed for use of patients who cannot pick up a shuttle from table level. It is fastened to the loom by a nail slipped through a hole in the metal plate which is a part of the rest and into a hole drilled in loom. It folds for storage and is stabilized when in use by means of a hook and eye.

Pictures submitted by Walter Reed Army Medical Center, Washington, D.C.

Picture Page



Plastic Plate Guard

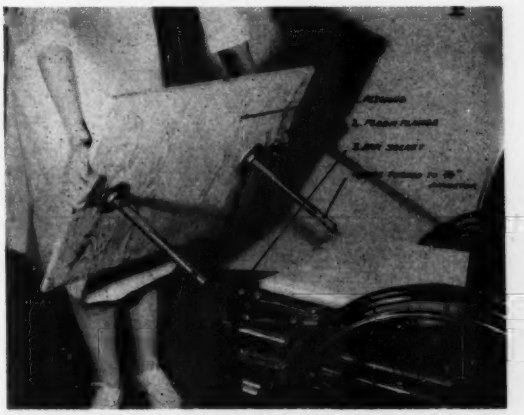
This guard was designed to prevent food from being pushed off the plate. It enables one-handed or hemiplegic patients to feed themselves.

Submitted by Virginia Stockwell, O.T.R., chief of occupational therapy, VA Hospital, Little Rock, Ark.

Lapboard

This particular lapboard allows the patient much freer access to the wheels of his chair for manipulation than is possible with other types of lapboard. It is suitable, however, only for patients whose trunk balance is sufficient to permit the removal of their wheel chair arms.

The lapboard is constructed of plywood measuring ½ inch by 18 inches by 27 inches (1) and is designed to fit any standard sized wheel chair with removable arms. Two galvanized floor flanges (2) are attached to the underside of the board with ½ inch flathead screws. Two pieces of brass lined plumbers pipe measuring 7/8 inch by 12 inches, threaded at one end (A), constitute the legs of the board. The ends (B) which are to be inserted into the front sockets (3) of the wheel chair arm must be turned on a metal lathe until the outside diameter of the pipe measures 3/4 inch (4). The length of the pipe and the location of the flanges is determined by the body build of the patient, location of wheels and width of wheel chair. Several coats of bar-top varnish or a Formica covering is essential to provide a hard, stain resistant surface. Approximate cost of materials for flanges, pipe and wood is $3.80.



Submitted by Patricia Plummer, O.T.R., State University of Iowa Hospitals, Iowa City, Iowa.

NATIONALLY SPEAKING

From the President

Occupational therapy has always been difficult to define in clear, concise terms. Through the years of its formal being, the definitions evolved have never quite matched its purpose, or the contribution it makes to the treatment of the patients it serves. Perhaps this is because there may be a difference in what we do and what we think we do, perhaps because the means used to achieve our purpose has been difficult to assess and discuss in terms of the attainment of specific therapeutic objectives. Whatever the cause, this lack of a precise definition has often been a stumbling block in the area of effective professional communication. If we are unable to define occupational therapy to our own satisfaction, how can we expect our professional colleagues to completely understand what we do.

Before any group can define its function, it must set down factually its objectives, the procedures it uses to achieve these objectives, and finally, its function in relation to those of allied groups. This is not an easy task, or one that can ever be said to be completed. It is a continuing and on-going process, particularly in the fields associated with medicine.

Five years ago, as you will remember, it was determined that the practicing occupational therapist urgently needed basic source material. The clinical procedures committee was established to meet this need. Sixty-three occupational therapists have contributed to the committee's work. The result of their collaboration has more than met the need as originally outlined. The completed edition of what is really a five year report, "The Objectives and Functions of Occupational Therapy," has recently come from the press. It is a remarkable book—clear, concise, factual and truly useful. The practicing occupational therapist will find it a more than welcome reference, the teacher a valuable outline of doctrine, the student a boon, and all occupational therapists will find in it the material from which they can reassess their own definition of their profession.

The facts are so simply stated that they have obviously been evaluated and weighed to insure that they are a true reflection of current clinical practice. There is no embroidery here, no romanticized interpretation. The facts are presented in the classic manner as they are, not as one might wish them to be. From material such as this, only improved clinical practice can result.

As we continue in our effort to define our function and to determine boundaries for this function, we must be realistic. We must begin to prove in the classic manner, using research techniques, that we do meet our objectives. To date most of our deductions have been empirical. If we are to reach a secure and recognized maturity, we must verify our clinical deductions. When we have done this, and only then, can we define occupational therapy in the way that will satisfy our professional integrity, and at the same time make it easy of interpretation to others.

This may appear to be an unattainable goal. Each of us, however, can in a small way begin to contribute toward its attainment. How? Through improving and stabilizing our own methods of observation, of evaluation, of recording, and of comparing our treatment objectives, procedures and results. Clinical observation and deduction is productive, but it is not enough. It may, however, if continually assessed, provide a pool of specific information that will stimulate some of us to put it to the test of verification. Even without verification, the clarification of our thinking resulting from constant channeled assessment, will be more than worth the effort.

The very idea of research seems to frighten most occupational therapists. We must recognize that its methods are not solely reserved for scholars, the gifted, those with leisure time and the specialists. With help and guidance we can make use of its methods to prove much of what we have observed clinically. When we have done this, we can begin to think of progressive scientific development.

RUTH A. ROBINSON, Lt. Col., AMSC
President.

From the Executive Director

This is a salute, thanks, and congratulations to the Rocky Mountain and Pacific Coast Occupational Therapy Associations (Colorado, So. California, No. California, Oregon, and Washington) and to the approximately 450 therapists their membership represents who planned and arranged so graciously and efficiently for the extensive field trip I have just completed.

This tour of about 8,000 miles of accumulated travel over a period of approximately five weeks beginning with the April midyear meeting at Denver included individual visits to hospitals and rehabilitation centers of all types, crippled children's schools, all the Pacific Coast approved occupational therapy schools, and three proposed new ones getting ready to establish curricula (University of California School of Medicine, University of Washington School of Medicine, College of Medical Evangelists.) These

visitations totalled 50 and involved special meetings with medical staffs, departmental staffs, faculties, research staffs of special projects, student affiliation directors, medical advisory committees, and the annual banquet of the Tacoma Chapter of the International Council for Exceptional Children at which I spoke.

The meetings with the five state associations were highlights of those weeks, presenting as they did the opportunity to discuss informally topics of interest and concern on which we are all working for improved professional standards in technical practice, in education, and in our vital relationships with other professional groups. Our discussions centered on how to increase effectiveness in communications within the Association between the many bodies which are the core of the organization, national and state association finances, personnel policies, and administrative practices, malpractice provisions, committee activities, publications, research and special studies, formation and utilization of medical advisory boards, definition of the changing role of the O.T.R. in treatment programs, our direction in professional education and graduate study.

The variety of the schedule which was arranged by each local group is indicative of their alertness to and broad comprehension of the gamut of our professional frontier today—from details of the clinical role of the practicing occupational therapist to the necessity of our professional role in joint relationships with other allied groups, both technically and administratively. Marked medical and administrative support from institutions, agencies and communities was apparent throughout the trip, and signifies the backing which these therapists and state associations have achieved. All of this demonstrates vividly what we repeatedly recognize as the unmistakably important place which each AOTA member occupies individually and collectively, and the responsibility he carries in making our profession what it is.

I hope this tour proved as stimulating and challenging to the areas and therapists visited as it was to me, representing liaison with the national headquarters. Congratulations again on your many accomplishments, and thanks for the wonderful reception you accorded—Southern hospitality in that famous West Coast way! A summary of the itinerary is listed for your interest.

Denver, Colorado, Area

Association business. Midyear meetings of the executive committee, the Board of Management and education committees of AOTA.

Professional contacts. Dinner during Dr. Winthrop M. Phelps' seminar. OT department, Colorado State University, Ft. Collins, Colorado. Dinner with the director, medical staff and OT staff of the Children's Hospital, Denver.

Los Angeles, California, Area

Association business. Meeting of the Southern California OT Association.

Professional contacts. Meeting with the staffs of the OT, PT and PM & R departments of the College of Medical Evangelists. Visits and luncheon with the staffs of the OT and PT departments and deans of appropriate faculties at the University of Southern California. Visits to Rancho Los Amigos in Hondo, Long Beach V.A. Hospital, and California Rehabilitation Center, Santa Monica.

San Francisco, California, Area

Association business. Meeting of the Northern California OT Association.

Professional contacts. Fairmont County Hospital, U.S. Naval Hospital at Oakland, luncheon with medical advisory committee at Mills College, chief of the department of PM & R at the College of Medicine, University of California. Meeting with the dean and staff of the OT department at San Jose State College and Agnews State Hospital.

Portland, Oregon, Area

Association business. Meeting of the Oregon OT Association.

Professional contacts. Staff of the University of Oregon Medical Center, State Division of Crippled Children, and staff of the GM&S and TB services of the University Hospital, VA Hospital, Morningside Hospital, Holladay School for Crippled Children, Holladay Park Hospital, Rehabilitation Center, Oregon State Hospital, and the Oregon State TB Hospital.

Tacoma, Washington, Area

Association business. Meeting of the Washington OT Association.

Professional contacts. Banquet speaker for International Council for Exceptional Children, luncheon with the medical advisory board and a full day meeting with directors of student affiliation centers of the College of Puget Sound, informal meeting with OT students of the College. Visited the Tacoma-Pierce County School for Crippled Children, Hough School at Vancouver, and VA Hospital at Vancouver.

Seattle, Washington, Area

Professional contacts. Visit and luncheon with chief of the department of PM&R and staffs of the OT and PT departments of the University of Washington, meeting with director and OT staff of the State Department of Health, Division of Hospitals and Nursing Homes, Rehabilitation Center, Warren Ave. School, Spastic Children's Clinic, U.S. Public Health Hospital, United Cerebral Palsy Sheltered Workshop.

Walla Walla, Washington, Area

Professional contacts. Whitman College and Veterans Administration Hospital.

MARJORIE FISH, O.T.R.
Executive Director

From the Director of Education

In this, the year of the second congress of the World Federation of Occupational Therapists, we salute the growing number of American therapists who are studying and working abroad, the graduates of foreign schools, whether they be working in this country or elsewhere, and the many students from abroad enrolled in

occupational therapy curricula in this country. During the academic year, 1956-57, there were 33 students representing 14 countries enrolled in 12 of our regular college or university occupational therapy courses, and 7 foreign students taking special courses. During the 10 years prior to 1956, there were 52 foreign students who completed the curriculum in occupational therapy in 14 American schools. These represented 17 countries. It is interesting to note that in one academic year the number of foreign students was more than one half the total number enrolled during the preceding 10 years. Although figures are not yet complete for the academic year, 1957-58, we suspect the total is continuing to rise at a similar rate.

The national office continues to receive many inquiries from graduates of foreign schools relative to working or pursuing further study in this country. Many of these graduates are desirous of taking our registration examination. We feel it is of appropriate interest to the readers to note that the Board of Management of the American Occupational Therapy Association, in 1957, approved a revision of the *Policy on International Reciprocity* as follows:

The registration committee recommends that reciprocity of registration on the basis of examination be established with foreign occupational therapy associations, provided:

A. That in the opinion of the registration committee the curriculum of the schools of occupational therapy be comparable with those in the U.S.A.

B. That such reciprocity shall be granted on an individual basis only, in accordance with the following requirements:

1. The occupational therapist must be a graduate of an approved school of occupational therapy (accredited by the country's medical association, occupational therapy association, or other qualified professional organization).
2. The occupational therapist must be recommended by the school director.
3. The occupational therapist must be qualified in all areas of occupational therapy.
4. The occupational therapist must be a member in good standing of his own association.
5. Applicants will be classified according to the following:
   a. Student therapist (one who enrolls in the clinical affiliation program of an American occupational therapy school).
      (1) A minimum of nine months of clinical experience in the U.S.A. required.
      (2) Experience to be secured at various affiliation centers in accordance with A.M.A. *Essentials* (periods of two months or more.)
      (3) Clinical affiliation reports to be submitted as for our students.
   b. Graduate therapist (one who is seeking advanced study under a program planned by an American occupational therapy school).
      (1) Nine months field experience in the U.S.A. required.
      (2) Experience to be secured in periods of two months or more.
      (3) Clinical affiliation reports to be submitted for each affiliation.
   c. Employed occupational therapist (not under the jurisdiction of an American occupational therapy school).
      (1) Twelve months of clinical work experience in an occupational therapy department required.
      (2) Experience to be in one occupational therapy department under the supervision of one O.T.R. in the U.S.A. or elsewhere.
      (3) Work record report to be submitted in place of clinical affiliation report.
      (4) The applicant must be recommended by the O.T.R. to write the registration examination.
      (5) Special exceptions to the requirements set forth in this section may be made, on an individual basis, by the registration committee in the case of experienced occupational therapists holding supervisory positions in the U.S.A.

This revision has accomplished the following:

1. The scope of the original policy has been broadened relative to supervision of the employed foreign trained therapist since the experience of the applicant for A.O.T.A. registration may be under an O.T.R. in any country. (See Section 5c2).

2. The original policy has been maintained for graduate and undergraduate students enrolled in U.S.A. schools, requiring that the clinical experience be in the U.S.A. (See Sections 5a1 and 5b1).

3. Provision has been made for exceptions for experienced foreign trained therapists holding supervisory positions in the U.S.A. (See Section 5c5).

The registration examination was first administered in its present form (300 multiple-choice items) in February, 1947. Since then, 46 graduates of foreign schools of occupational therapy have taken the examination. In 1953 it was decided to publish in the *American Journal of Occupational Therapy* the names of those passing the registration examination and to note, as "Passed with Honors," those persons having the five top scores for each administration of the examination. Two of those who have achieved this honor have been graduates of foreign schools. You will note in the 1958 *Yearbook* that 25 occupational therapy departments in 14 foreign countries employ persons currently registered with the American Occupational Therapy Association.

To all of these therapists who are so ably contributing to the ever-increasing growth of occupational therapy around the world—our heartiest congratulations.

Virginia T. Kilburn, O.T.R.
Director of Education.

From the Field Consultant

The appointment of a field consultant in rehabilitation came as a result of the expressed needs by practicing therapists for guidance and consultation in order to keep up with the rapid growth of rehabilitation services. To fulfill this need and bring about increased understanding of the total rehabilitation process is the sincere desire of the consultant.

Her availability has been made public in several ways. (1) The Newsletter carried an announcement of her appointment and a personal message from her to the membership when she assumed her duties. (2) Press releases were sent out by the director of public information. (3) The executive director sent announcements to all allied agencies with a cover letter emphasizing our desire to be of service.

There has been a limited number of requests for the services of the consultant but that is not discouraging since education in the use of a new service is a necessary step. Contacts through regional and state associations will be of great value in this respect. It is anticipated that the use of the Nationally Speaking column in the *American Journal of Occupational Therapy* and the monthly Newsletter will keep the membership aware of the availability of this service.

One major area of activity for the consultant will be to visit individual occupational therapy departments, rehabilitation centers and other institutions and agencies to establish, augment or revise rehabilitation programs. Periods of time need to be planned in such visits so that sufficient observation can lead to a thorough analysis and it will be through the feedback of information acquired from these analyses that the program will continue to flourish. The consultant can learn much from those ambitious workers in the field who have evolved a new approach. By critically evaluating these approaches and introducing them as reinforcement when the need is evident, the entire field of rehabilitation will advance more rapidly.

As she visits schools and student affiliation centers new material and improved techniques can be introduced so that they can be incorporated into the existing programs.

These first few months were scheduled as a period of orientation and the contacts made during this time will prove to be of great value to the consultant as she goes into the field.

In addition to some time spent in Washington at the Office of Vocational Rehabilitation the period of orientation has included:

Meetings attended

World Federation for Mental Health, New York.
United Hospital Fund Mental Health Meeting, New York.
National Recreation Association, New York.
Congress of Orthopedic Surgeons, New York.
Student Affiliation Council Meeting, Philadelphia.
Institute on Equipment Research for Handicapped Children, Southern Illinois University.
American Personnel and Guidance Association Convention, St. Louis, Missouri.

Speaking engagements

District of Columbia Occupational Therapy Association Institute on Activities of Daily Living.
Occupational Therapy Volunteer Committee of the United Hospital Fund of New York.

Course attended

Organization, Administration and Supervision, University of Pennsylvania.

Institutions visited

Columbia University Presbyterian Medical Center.
Institute of Physical Medicine and Rehabilitation.
Goldwater Memorial Hospital.
University of Pennsylvania Hospital.
Walter Reed Army Hospital.
Institute for Crippled and Disabled.

Duties assigned have been beneficial in giving a better understanding of the inner workings of the organization. Much time has been spent in taking care of correspondence. Many of the letters required inquiry and research within the available files. Information gleaned in this way has taken on more meaning. These letters are welcomed since they point out the need of the individuals.

One fact of interest is the number of letters received from high school and college students who want technical information to aid in writing term papers. Time consuming as they may be, these letters have to be processed since, with the emphasis on recruiting, we do not pass up an opportunity to inform young people of the potentials within the field.

Sincere appreciation is expressed to the Office of Vocational Rehabilitation for making this position possible and to the executive director and the entire American Occupational Therapy Association staff for their cooperation during this period of orientation.

Irene Hollis, O.T.R.
Field Consultant in Rehabilitation

Attention Convention Goers:

Effort on the part of your national permanent conference committee and the local conference committee is being exerted in planning a conference program to meet your needs. We therefore trust you will make a special effort to comply with their requests in evaluating your experience during the conference period.

Your evaluations and suggestions, over the years, have been carefully tabulated and formulated into tables and summaries. These tables and summaries are used by both planning groups. This year an appraisal committee has been appointed as a sub-committee under the permamanent conference committee.

The plan to date for collecting your evaluations of the 1958 New York conference is to have two questionnaires. The pre-conference questionnaire is to be made out at the time of registration (regardless of the day of attendance). The post-conference questionnaire is to be filled out the last day of your conference attendance. These will be the only times you will be asked for appraisals. We will remind you from time to time at the conference. Should the data collected be as factual as we hope it will be, we will try to have the results in AJOT for your enlightenment.

Clyde Butz, O.T.R.
Bertha Piper, O.T.R.
Bess Lande, O.T.R.
Patricia Plaisted, O.T.R.
Robert E. Belyea, O.T.R.,
Chairman Appraisal Committee

EDITORIAL

GLOBAL CONCEPTS

Never before except during war time have we, as American citizens, been so concerned with global or world affairs. Our preference for isolation has changed to an interest in other nations and their concern has become our concern. We have assumed a tremendous obligation but in typical American fashion, we all do our part in the hope that each small bit accumulates to a noticeable contribution of true value given without a selfish aim.

Individually occupational therapists are contributing to this world interest by accepting exchange positions. Professionally we are training foreign students in our professional schools. Typically we feel these exchanges are to our benefit because of the wealth of new experiences. We welcome these contributions.

And more recently we have taken an active part as an association by our active participation in the formation and success of the World Federation of Occupational Therapists. The second annual congress of WFOT is to be held in Copenhagen in August. The number of our members attending is a tribute to our interest and it is with pride that we can note the second president of this international group is our own member, Miss Clare Spackman, O.T.R.

We look forward with interest to this meeting which will help direct our future contributions on a global scale. Their concepts will guide us to an even greater growth and all of us will be richer for this free exchange.

AOTA Conference

New Formula For Communications

October 17 to 24
Hotel New Yorker

The New York Occupational Therapy Association welcomes you to an exciting conference in New York City this year. The theme is *Communications.* It seems everyone is interested in communications these days in this alive and fast-moving age. In our own everyday contacts with patients, doctors, nurses, staff, the grocer, the bus driver, etc., etc., etc., we communicate constantly and take the phenomenon for granted. Yet, with a little reflection we all realize that sometime, somehow, it "works better" and we're not always sure why. To learn the answer come to the conference.

The conference extends over three days: Tuesday, October 21, through Thursday, October 23. We have reduced the overall length of conference time at your request and we urge you to attend for the full three days so you have a chance to *learn* about communications, *see* and *hear* demonstrations, and actually *perform.* Although each day can be considered meaningful in itself we strongly recommend, for your greatest enjoyment and growth, to take in all three days which are: (1) the "learning" day, (2) the "seeing and hearing" day, and (3) the "doing" day. The total will add up to that sparkle in your own communication system that will be recognized the moment you return to your job. Here's how:

TUESDAY, OCTOBER 21

Registration ..... 8:30 a.m.— 6:00 p.m.
Commercial exhibits ..... 12:00 m.— 7:00 p.m.
Educational exhibits ..... 9:00 a.m.— 7:00 p.m.
First call (get together over coffee) ..... 9:00 a.m.—10:00 a.m.
On stage (grand opening) ..... 10:00 a.m.—10:30 a.m.
Briefing (your instroduction to communication, its meaning for you as an occupational therapist) ..... 10:30 a.m.—11:15 a.m.
In the laboratory (demonstration by the Princeton Perception Laboratory; see it with your own eyes, but can you believe it?) ..... 11:15 a.m.—12:30 p.m.
Overheard in the lobby (small group participation. Your opportunity to experience what

occurs as messages are transmitted from person to person) 2:30 p.m.— 4:00 p.m.

In the world (when disaster strikes your community, will you be prepared to help?) ..... 4:00 p.m.— 5:00 p.m.

In the Nation. Annual business meeting. Special features: See history unfold ..... 7:30 p.m.— 9:30 p.m.

WEDNESDAY, OCTOBER 22

Registration ..... 8:30 a.m.— 5:00 p.m.

Commercial exhibits ..... 9:00 a.m.— 5:00 a.m.

Educational exhibits ..... 9:00 a.m.— 5:00 a.m.

Eleanor Clark Slagle lecture..... 9:00 a.m.—10:00 a.m.
"Everyone Counts" by Miss Margaret Rood, O.T.R.

Charting the course ..... 10:30 a.m.—12:30 p.m.
The experts describe the how, the why and wherefore of communication. The anthropologist, psychologist, neurophysiologist, and the mass media expert examine the process. You will have a chance to raise questions and discuss ideas.

Discovering new lands ..... 2:00 p.m.— 5:00 p.m.
Choose your "studios" and participate in demonstrations of communication techniques used by the occupational therapist with the brain-injured, with the blind, the deaf, with the psychotic, et.al., in education, in treatment, in research.

Cocktails ..... 6:00 a.m.— 7:00 p.m.

Banquet ..... 7:30 p.m.— 9:00 p.m.

Designer collections ..... 9:00 p.m.

THURSDAY, OCTOBER 23

Registration ..... 8:30 a.m.— 2:00 p.m.

Commercial exhibits ..... 8:30 a.m.—12:00 m.

Educational exhibits ..... 8:30 a.m.—12:00 m.

Actor's studio (see ourselves as others see us) ..... 9:00 a.m.—10:30 a.m.

Run through (you've heard about communications, you've seen communications. Now do it yourself—here and back home)....11:15 a.m.—12:45 a.m.

News and reviews (share your reactions, comments) ..... 2:15 p.m.— 2:45 p.m.

Over the teacups (our leaders talk it over while we eavesdrop).. 2:45 p.m.— 3:15 p.m.

Finale ..... 3:15 p.m.— 3:30 p.m.

On the town: (your chance to tour the United Nations, shop dine, relax)

Around the world in 80 *minutes*
The United Nations furnishes the inspirational setting for a review of the international rehabilitation picture. W.F.O.T. meeting and report on Denmark meeting ..... 7:00 p.m.

FRIDAY, OCTOBER 24.

Five field trips are being planned and, so far, include the Institute for Physical Medicine and Rehabilitation in Manhatten; New York State Rehabilitation Hospital in West Haverstraw; and the Brooklyn After-Care Clinic, a psychiatric out-patient unit. Other hospitals will be available for visiting on an open-house basis. A field trip information desk and hostess desk will be at your disposal at the conference. All this and New York City too—the unique vacation spot where visitors come from all over the world for shows, fashions, museums, concerts, night clubs, sight-seeing and excitement unmatched anywhere on earth.

Of vital importance to you as an Association member, will be the pre-conference meetings where you will discover what actually goes into the functioning of our Association—how can we raise our professional standards; what's being done in legislation and civil service; what special studies and research projects are in progress: what are we doing about recruiting occupational therapists—these and many other vital issues that you feel strongly about are all being considered and this is your opportunity to find out and participate for your own professional advantage. Here is the schedule of pre-conference meetings:

FRIDAY, OCTOBER 17

*Council on Education ..... 2:00 p.m.— 5:00 p.m.

*Sub-group Curriculum Committee ..... 7:00 p.m.—11:00 p.m.

Graduate Study Committee ..... 7:00 p.m.—11:00 p.m.

SATURDAY, OCTOBER 18

Joint Education Committee..... 9:00 a.m.—11:00 a.m.
Curriculum Committee .....11:00 a.m.— 5:00 p.m.
Student Affiliation Committee.....11:00 a.m.— 5:00 p.m.
*Council on Education ..... 7:00 p.m.—10:00 p.m.
Recruitment and Publicity ..... 7:00 p.m.—10:00 p.m.
Legislation and Civil Service..... 7:00 p.m.—10:00 p.m.
Clinical Procedures Committee.... 7:00 p.m.—10:00 p.m.
Recognition of OT Assistants.... 7:00 p.m.—10:00 p.m.
State Counselors and Supervisors 9:00 p.m.—10:00 p.m.

SUNDAY, OCTOBER 19

House of Delegates ..... 9:00 a.m.—10:00 p.m.
Editorial Board .....12:30 p.m.— 4:30 p.m.
Special Studies Committee ..... 7:00 p.m.—10:00 p.m.
Clinical Procedures Committee.... 7:00 p.m.—10:00 p.m.
Special Interest Groups ..... 7:00 p.m.—10:00 p.m.

MONDAY, OCTOBER 20

*Board of Management ..... 9:00 a.m.—10:00 p.m.

*Leader Training Group ..... 9:00 a.m.—10:00 p.m.

Special Project Fund Committee ..... 7:00 p.m.—10:00 p.m.

Appraisal Committee ..... 7:00 p.m.—10:00 p.m.

Official opening of exhibits ..... 7:00 p.m.—10:00 p.m.

Post-conference meetings

FRIDAY, OCTOBER 24

*Board of Management ..... 9:00 a.m.— 1:00 p.m.

SATURDAY, OCTOBER 25

*Medical Advisory Council ..... 9:00 a.m.— 4:00 p.m.

*Membership is invited to attend all pre-conference meetings with the exception of those starred.

FOREIGN AWARDS

Three occupational therapists are attending the congress of the World Federation of Occupational Therapists as part of their appointments for awards. Miss Marguerite Abbott, M.A., O.T.R., will be a visiting American professor in occupational therapy at the Astley-Ainslie School of Occupational Therapy, Edinburgh, Scotland. Miss Abbott, assistant professor in occupational therapy, Columbia University, and executive director of the World Commission for Cerebral Palsy, International Society for Welfare of Cripples, will also do graduate work in international comparative education at the University of London before returning to New York City.

Miss Marjorie Ball, O.T.R.

Miss Marjorie Ball, M.A.,O.T.R., associate professor and director of the occupational therapy course at Colorado State University, Ft. Collins, Colorado, has been awarded a fellowship to establish an occupational therapy department in a French rehabilitation clinic, Les Charmilles, at Valenton, a suburb of Paris. Miss Ball's fellowship is from the Atlantique French-American Association, one of many exchange programs for experienced workers in the welfare and health field. She will start teaching at Les Charmilles in October after a visit to Brussel's World Fair, the congress of the World Federation of Occupational Therapists and a month in Paris.

Miss Marie Louise Franciscus, O.T.R.

Miss Marie Louise Franciscus, director of training for occupational therapy at the College of Physicians and Surgeons, Columbia University, New York City, has received the Government's first Fulbright award to be given for research in the clinical and educational phases of occupational therapy in the United Kingdom. She has been assigned as a research scholar based at the Liverpool School of Occupational Therapy at Huyton, England, from September through June. Her program includes an observation and lecture tour of the six other schools teaching occupational therapy in England and the one school in Scotland. Miss Franciscus will attend the world congress of the World Federation of Occupational Therapists in Copenhagen as a delegate from the American Occupational Therapy Association.

This issue of the *American Journal of Occupational Therapy* is published in two parts. Part I is the regular bimonthly issue and contains information relative to the 1958 annual conference to be held in New York City, October 17 to 24.

Part II of this issue contains the lectures from the conference held in Cleveland, Ohio, October 19 to 25, 1957. Since this was an institute-conference, with audience participation, there were few lectures. These therefore can be printed in full without abstracting the material as is usually done in our annual conference issue.

Finger Extension . . .

(*Continued from page* 171)

the wire does not hold the fingers in extension, try heavier wire until one is found that will. Then have the patient flex his fingers against this resistance. If he cannot flex easily, a lighter wire must be used, even though some extension is lost in so doing. Remember, in most cases, it is better to sacrifice the ideal for the practical. The ideal position may be theoretically better, but it cannot be justified when the patient does not use the brace consistently because of a lack of practical application. While in this testing position, the length of the cable housing may also be determined. The extension arm should be three-quarters of an inch longer than the distance from the tape to the base plate. At the proximal end of the arm, one-quarter inch of cable housing is snipped off exposing the wire. This exposed piece of wire is bent to a 90° angle and the cable housing is soldered to the wire. One-eighth of an inch of cable housing is snipped (cut) off at the distal end, and the exposed wire is bent to an 90° angle vertically while the wire is held with the 90° bend at the proximal end in the horizontal position. The extension bar is now completed.

The steel ring (H) is cut from a .035 stainless steel sheet. A strip, one-quarter inch wide by three and one-half inches long, is used. The edges are sanded slightly round, and the strip is bent around a piece of one-inch pipe. The ring is then tested on the finger allowing one-eighth of an inch clearance on all sides, (approximately one-fourth-inch larger in diameter than the finger). The ring ends should overlap about one-fourth inch and should be soldered together at this lap joint. The ring is now soldered to the distal end of the extension bar. The ring and bar are placed on the finger; aligned correctly; the location for the proximal end is marked on the back plate, and finally soldered into place. Before covering the brace with plastic, the ring is wound with adhesive tape to prevent starved edges. Illustrations showing the operation of this finger extension mechanism are shown in Figure 2.

CONCLUSION

The finger extension mechanism described here, provides a system of passively extending the finger in a manner which conforms to the general contour of the hand. This is the primary objective of this mechanism, and it is superseded in importance only by the extension itself. This extension mechanism may be constructed for any one, or any combination, of the four fingers of the hand.

SUMMARY

In the past four articles, we have described the best of a whole array of functional splints designed at the California Rehabilitation Center within the past five years. They have been chosen for two reasons: (1) they have proved effective and satisfactory, and (2) the use of common parts has allowed the brace to be readily adapted to the patient's changing needs as he progresses from one stage of recovery to another. The splints have proven extremely useful as a part of the rehabilitation program for patients with disabilities involving the upper extremities.

Activity for the Aged . . .

(*Continued from page* 175)

tered workshop would be a realistic approach to at least one phase of occupational therapy. We hypothesize, on the basis of a year's experience with this approach, that it holds important implications for the retention of a self concept characterized by feelings of adequacy as opposed to one characterized by more or less complete deterioration and feelings of futility. It seems to us that the need to implement such an approach in work with the aged becomes clear when social-psychological factors are taken into account, and when the meanings of work and productivity are considered in relation to the individual's view of himself as an aged person.

An area of further psychological investigation would be the study of those individuals who could most profit from such an activity as opposed to others who, for a variety of reasons, perhaps largely personal, would not. Another, most significant in this period of steady increasing numbers of retired and semi-retired but non-institutionalized aged, is in the area of utilization of this approach outside of the institutional setting but in recreational centers for the aged.

CONCLUSIONS

A sheltered workshop program, realistically geared to the limitations of the aged may provide an effective recreational-vocational program and one of the best approaches to occupational therapy with them. It combines interpersonal contact, feelings of sustained productive capacity, feelings of retention of skills, and further involves a monetary reward, thus defining the individual's worth in terms congruent with those of the society he knows and understands. Immediate benefits may be in terms of manageability, but a more subtle and more important personal development may be some retention of an adequate self image. Further observation and

experimentation will be carried out in an attempt to delineate the developments in self concept associated with participation in a sheltered workshop program as described and to determine a more adequate basis for the selection of individuals for participation.

SUMMARY

An experimental sheltered workshop program was carried out in a home for the aged. The approach was initiated because of an hypothesized relationship between work activity and self image among the aged. Projects selected and described fell within the limits of the psychomotor abilities of the greater part of the population under consideration. Wages were paid for production. Case illustrations were presented to indicate the areas of effectiveness of the program and to show some of the problems involved in its administration. Lines of development for further study of the nature of the work-self-image relationship and of other personality factors involved in a participation in such a program were indicated.

The study was carried out with the cooperation of the staff of the Orthodox Jewish Home. Thanks are due Jacob Gold, director, Genevieve Blumenthal, social worker, and Mrs. David Earlix, sheltered workshop supervisor. We wish also to acknowledge the helpful guidance of the Jewish Vocational Service of Chicago.

REFERENCES

1. Donahue, Wilma, Hunter, W., Coone, D. "The Effects of Activities Programs Upon the Socialization of Residents of Old Age Homes." *Jour. of Gerontology*, 1952, 4, 478 (abs.)
2. Lakin, M. "Clinical Use of the Bender Visual Motor Test in Psychological Assessment of the Aged." *Jour. of the American Geriatrics Society*, Sept., 1956, 4, 909-919.
3. Anderson, J. E. (ed.) "Psychological Aspects of Aging." Proceedings of a conference on planning research, Bethesda, Md., April 24-27, 1955, Washington, D. C. American Psychological Association, Inc., 1956.

Work Therapy . . .

(*Continued from page* 176)

2. It contributes a marked increase in morale among these patients. For them, it symbolizes an improvement in their condition; it affords them a measure of prestige to be allowed "ground privileges," and it assists in rebuilding self confidence when given responsibility once again.

3. It serves for some as an all-important bridge between the simple sheltered ward situation and the complex working world; in fact, it may even shorten his hospitalization through speedier adjustment.

4. The patient receives satisfaction from rendering service to others within the hospital, thereby receiving recognition as an important contributing member of the group.

5. It is most effective in increasing the layman's understanding of the patient with a mental problem. The reactions of personnel cooperating in this venture have changed from reluctant acceptance to enthusiastic endorsement. Indeed, some supervisors have expressed the feeling that they have derived as much value from the experience as have the patients, and they have received satisfaction from the knowledge that they have been the means of assisting a patient on his road to recovery.

6. During the twelve months that this program has been tried here, over two hundred patients have participated in work therapy. The average number of patients assigned to jobs at any given time has been thirty-six.

7. There have been some failures among the patients assigned to this program. Generally, the reason for this has been premature placement of a too anxious patient. Since one of the purposes is to provide a trial period for evaluation of the medical treatment, the patient may be placed on the job too soon. A specific example of this concerns a patient who was assigned as a receptionist. After two weeks, both the supervisor and the patient himself realized that he was regressing. He requested return to the closed ward for further treatment and was placed on insulin therapy. Had this soldier not had this trial working period, he might have been returned to duty only to be re-admitted to the hospital—a costly procedure for all.

CONCLUSIONS

From the experience gained at this hospital during the experiment, we conclude that:

1. A patient should not be placed in a job merely to satisfy the needs of the hospital. Many sections may tend to become dependent upon patient help. They will call for assistance, and sometimes seem to lack understanding of the purpose of the program due to the pressure of their own needs. True, there may be a patient available at this time for work therapy but the particular job might not serve the best interests of the patient. For example, help might be needed in the library for a quiet, detailed and confining job. It would not be considered therapeutic to place a gregarious, active, former paratrooper in this assignment. Should this patient be ineffective in this job, the resulting failure would be twofold; his ego might be shattered and the attitude of personnel toward this program could be jeopardized. For the above reasons it is necessary to maintain a file of job descriptions which will include the physical environment, task requirements and responsibilities, working hours, and a brief statement of supervisor's characteristics.

2. The utmost consideration should be given to the interpersonal relationships which will be involved in assignments. For example, a young and timid patient who had been severely depressed was exceedingly successful as a ward runner on a ward where every attempt was made by personnel to include him as a contributing member of their staff. The nursing supervisor, as well as the other nurses, gave this patient the consideration and understanding which he greatly needed. His response to this type of treatment was such that he became an invaluable member of the group. Had this patient been subjected to a critical, authoritative type of supervision, the results might have been quite different. He might have become frightened, resulting in an inability to succeed in a fairly simple assignment.

3. Care should be taken to insure that the patient is "ready" for a job. Closed-ward patients sometimes become so anxious to be placed on a job in order to receive ground and other privileges, that they are referred prematurely. This can result in a failure which may jeopardize the patient's entire treatment. It is imperative that there should be agreement by those concerned, usually the doctor and the therapist, that the patient is

capable of adequate performance before he is given an assignment.

4. As a final precaution, it cannot be too strongly emphasized that the initiation of a program such as this will be far more effective if it is developed very slowly. It is our opinion that it should be begun with a single patient and a supervisor who has been well oriented to the purposes of the program, and is cooperative and willing to share in an experimental venture. In this way, all of those concerned with the program, the doctor, the patient, the occupational therapist and the job supervisor form a group whose efforts, evaluations and recommendations can be the basis of future growth. It is far better in the beginning to achieve good results with one patient than a modicum of success with several. In the long run the chances for such a program being desired, accepted and utilized will be far more satisfactory.

On the basis of our experience with work therapy, we feel that this method would be an adjunct in the treatment of physically disabled as well as psychiatric patients.

ACKNOWLEDGEMENT

Appreciation is extended to Major Thomas B. Hauschild, MC; Captain Miron W. Neal, MC, psychiatric section, and Major Walter H. Moore, MC, chief, physical medicine service, Letterman Army Hospital, for their encouragement and cooperation in conducting this program. It is through their interest that the program has been successful.

Sliding Board . . .

(*Continued from page* 177)

sisting person will reach down with his free left arm to lift first the left leg and then the right leg of the patient, and place each in the car. To get out of the car the process is reversed.

To facilitate the transfer technique, it is best if the wheelchair is on the curb of a sidewalk, making the sliding board level with the car seat or even sloping downward, depending on the height of the curb. For getting out of the car, if the wheelchair is placed in the street, off the curb, the sliding board again will be sloping downward.

MATERIALS AND ASSEMBLY

1. Three-quarters inch by nine and a quarter inch pine for smaller board.
2. Four roll-weight-nail-on casters one inch or three-quarter inch in diameter for smaller board.
3. For larger board use three-quarters inch by eleven and one-half inch by thirty-five inch plywood.
4. A piece of hard aluminum or stainless steel, one and one-half inch by nine inches bent lengthwise to act as "stop" on one end of larger board.
5. Enough 18 gauge hard aluminum thirty-five inches long, one and one-sixteenth inches wide and one-half inches deep to line two tracks on larger board.
6. Approximately 24 screws to set the metal tracks and "stop."

Smaller board. It is suggested that the smaller board be made first so that the tracks on the larger board can be lined up accordingly. Board should be sharply beveled on either end so that the middle of the board is three-quarters inch in thickness and either end is one-fourth inch. All corners should be rounded, and board should be finely sanded and covered with varnish and waxed to make it smooth. Four casters are countersunk one-fourth inch below surface on the flat under side of board.

Larger board. Board should be rounded on edges running lengthwise of board. The two tracks should be cut out to correspond with the casters set in the smaller board to allow a free and easy slide and some side to side motion. Dado is cut one and one-sixteenth inch wide and one-half inch deep. Tracks are lined with 18 gauge hard aluminum. Screws that set tracks should be countersunk so that they do not interfere with the action of the casters. Metal stop is screwed into one end of the board only. Tracks may be slightly greased to offer a smoother gliding surface but this usually is not necessary.

Letters to the Editor

To the Editor:

Re: the national special studies committee report that appeared in the March-April issue of AJOT. This report concerns the special study survey which was conducted on a national basis to find out about research projects being done in the United States during 1956-57.

We understand that 4400 questionnaires were sent out, but only 103 were returned. Therefore we believe this survey to be invalid. It misrepresents the true facts of research being conducted in occupational therapy. A twenty per cent return is considered by survey researchers to be poor, though such surveys are occasionally published. In this survey only two per cent returns are shown, though this information is not divulged in the article.

We feel that this survey totally misrepresents our organization and should not have been published. Other national organizations, who are interested in research being done in occupational therapy, will undoubtedly be misled by this report, as many readers have already been because the complete statistics were not given.

The Michigan Research Committee
Helen Barrows, O.T.R.
Bobbe Miller, O.T.R.
Lois Mills, O.T.R.
Lyle Spelbring, O.T.R.
Josephine C. Moore, O.T.R. *Chairman*

DELEGATES DIVISION

ARKANSAS

Delegate-Reporter, Virginia Stockwell, O.T.R.

Recruitment is still an important project of the Arkansas Occupational Therapy Association. We have an active recruitment chairman and all members have contributed time for talks to students and other interested groups. One exhibit is getting rather worn from its travels around the state.

Increased awareness of occupational therapy and the value of training is shown in two new positions activated in the state and university hospitals where there have not been registered therapists. Also, an occupational therapist, Ruth Leebrick, is organizing a new unit of the vocational rehabilitation service for the mentally disabled. She is coordinator of therapies. This unit is located at the State Hospital but she is employed by the vocational rehabilitation department of the Arkansas State Board of Education. There will be six therapies—home-

making, arts and crafts, special education, recreation, commercial and industrial arts. This is the first unit of this kind in this country.

Two outstanding speakers at our meetings during this past year were Dr. H. B. Mulhone, the director of research and education at the State Hospital, speaking on "Tranquilizing Drugs and Implications for Occupational Therapy"; and Dr. Anne Simon, clinical psychologist at the University Hospital, speaking on "Play Therapy."

Our president and delegate have been asked to serve on a committee on training for physical and occupational therapists. This is a planning committee of the Arkansas committee for the handicapped. One meeting has been held and was attended by Mrs. Sorensen.

OFFICERS

President .....Betty Sorensen, O.T.R.
Vice-President .....Dorothy Marsh, O.T.R.
Secretary-Treasurer .....Janet Hoban, O.T.R.
Delegate .....Virginia R. Stockwell, O.T.R.

HAWAII

President-Reporter, Gertrude McKinney, O.T.R.

The Occupational Therapy Association of Hawaii held its annual meeting in March. The past year was a most successful year and the committee reports were an indication of definite progress.

The public relations and recruitment committee, working closely with the scholarship and publicity committee promoted a recruitment program. Through the interest of the dean of student personnel at the University of Hawaii eleven students who were interested in occupational therapy as a career, were invited to a luncheon given by the Association. Arrangements were made with the University of Hawaii and the public library of Hawaii to accept printed matter collected and compiled into booklets. A speakers bureau was maintained.

The education and finance committee conducted the annual fund raising project and the printing and selling of the Association's calendars. This fund was used as a means of awarding an annual scholarship and to defray other educational projects.

The members of the Association voted to award a five hundred dollar scholarship outright, the recipient privileged to borrow an additional five hundred dollars if so warranted. One scholarship was awarded this past year.

The committee on professional standards and legislation spent considerable time in inspecting and evaluating the constitution and by-laws. Recommendations of amendments were accepted and voted upon at the annual meeting.

A file of all qualified occupational therapists in the Territory, and a file of records and printed copies of all legislation which regulates the practice of an occupational therapist were set up. A form was devised for collecting data on salary ranges and status of positions in hospitals and institutions in the Territory. Inquiries and applications for occupational therapy placements in the Territory were handled by the committee.

A committee on standards was formed to establish an award which would give recognition to an outstanding therapist.

The programs for the general meetings during the year covered such topics as: group dynamics; advances in the geriatric program, both in the Territory and on the mainland; vocational rehabilitation; sheltered work shops; and the program for the blind being conducted in the Territory.

The members of the Association voted to invest $300.00 of their funds in stocks in the local utility companies.

After a year of exhausting research a history and handbook of the Association was compiled and edited.

Recommendations for the following year: (1) consider having a medical advisory board; (2) continue a recruitment program; (3) consider the possibility of further investments; (4) look into the possibility of conducting a workshop.

OFFICERS

President .....Gertrude McKinney, O.T.R.
Vice-President .....David Murata, O.T.R.
Secretary .....Rose Lee, O.T.R.
Treasurer .....Shirley Tolliver, O.T.R.
Delegate .....Dorothy Park, O.T.R.
Alternate Delegate .....Janet Hirata, O.T.R.

FLORIDA

Delegate-Reporter, Florence L. Walters, O.T.R.

The highspot of a successful year for the members of the Florida Occupational Therapy Association has been the establishment of a School of Related Health Services at the University of Florida. Degree programs in occupational therapy, physical therapy and medical technology will be offered beginning in September, 1959. Since this will be the first school in the "deep south" to train occupational therapists, we are looking forward to the time when the scarcity of therapists can be alleviated and Florida can boast of more than 25 active members.

"More service to the members of FOTA" has keynoted our efforts this year. A periodic newsletter has been inaugurated, with the sixth issue about to appear. A placement service and general information file has been compiled by the vice-president for the use of those desiring information about members or available positions. We have been successful in adding a winter meeting to our schedule, so that for the first time we have had more than two meetings a year. One of the problems deterring frequent meetings is the fact that members are scattered from one end of our long state to the other. We have encouraged the formation of districts wherever a reasonable number of therapists are concentrated. Those in the Miami area have been the first to do so, and reports from this district have been enthusiastic.

Our profession has been well represented at meetings, workshops and seminars. Members attended Margaret Rood's seminar on proprioceptive facilitation in Orlando, the Florida Society for Crippled Children's annual meeting in St. Petersburg, the Florida Medical Association's annual meeting in Miami, the Physical Therapy Chapter's regional and state meetings, the regional recruitment workshop in Richmond, and the American Hospital Association's institute for occupational therapists in Boston.

The occupational therapy departments in the state have demonstrated the ability of our members to organize excellent treatment program and achieve praiseworthy results despite limited personnel. The treatment and rehabilitation of amputees was demonstrated at the Katherine Payne Rehabilitation Center in St. Petersburg at our fifth annual meeting in May, 1957. At our fall meeting, we visited the Forest Park School for handicapped children in Orlando, and also toured and heard a lecture of activities of daily living devices at the Nila Kirkpatrick Covalt Rehabilitation Center in Winter Park. At a meeting in Hollywood, we visited the South Florida State Hospital and were privileged to hear Drs. Arnol Eichert, Mordecia Haber and Louis Graubard lecture on the philosophy of the establishment, group psychotherapy, and psychodrama.

At our annual meeting this May, we were the guests of the staff of Sunland Training Center at Gainesville where we heard an enlightening lecture by Dr. C. H.

Carter on the causes of mental retardation and epilepsy. Dr. Darrel Mase, dean of the School of Related Health Services, detailed plans for the curriculum in occupational therapy and the organization of the occupational therapy department at the soon-to-be-completed teaching hospital at the J. Hillis Miller Health Center of the University of Florida in Gainesville.

We are sad to announce the death of one of our most dedicated members, Martha Gill of Orlando. In memory of both Martha Gill and our beloved first president, Sue Linsin, who passed away in 1956, we have joined with the physical therapists in the state in setting up a scholarship fund for eligible students in both occupational therapy and physical therapy at the School of Related Health Services.

OFFICERS

President ..... Miriam Thralls, O.T.R.
Vice-President ..... Etta Harkness, O.T.R.
Secretary-Treasurer ..... Caroline Smalley. O.T.R.
Delegate ..... Arlene Krul, O.T.R.
Alternate Delegate ..... Ruth McDonald, O.T.R.

INDIANA

Delegate-Reporter, Wilma J. Franz, O.T.R.

The monthly meetings of the Indiana Occupational Therapy Association have been well attended. The programs were of interest to many because of their variety and the disability areas represented. Special meetings of the association included the annual occupational therapy-physical therapy meeting, the Kentucky-Indiana annual joint meeting, the popular dinner meeting, and two statewide meetings. On St. Patrick's Day a successful fund raising card party was held.

The northern district of the Indiana Occupational Therapy Association has completed its second year. A variety of programs were presented during the Saturday monthly meetings. These meetings were held at different occupational therapy departments throughout the district.

A placement service for occupational therapy in Indiana has been established this year. The placement chairman has available upon request a current list of existing vacancies in Indiana.

The first issue of the IOTA newsletter has been published.

The recruitment and publicity committee is developing some long range plans in order to better reach the cities and towns throughout Indiana with information about occupational therapy in general and our new occupational therapy school in particular. An excellent article about occupational therapy and this school was published not only in an Indianapolis paper, but also in the home town newspaper of every student presently enrolled in occupational therapy at Indiana University. By next year we should be able to report on the effectiveness of the planned recruitment program.

OFFICERS

President ..... Edna Faeser, O.T.R.
Vice-President ..... Mary Sahs, O.T.R.
Secretary ..... Mary Lou Godette, O.T.R.
Treasurer ..... Elaine Bates, O.T.R.
Delegate ..... Wilma Franz, O.T.R.
Alternate-Delegate ..... Margaret Smith, O.T.R.

LOUISIANA

Delegate-Reporter, Garnet Hines

Now that the Louisiana Occupational Therapy Association has become a member of the American Occupational Therapy Association, emphasis has shifted from by-laws and constitutions to making the State of Louisiana occupational therapy conscious. Of course, this will take time but the enthusiastic members are not at all discouraged.

Although this organization is young, much work has been and is being done. Vocational counselors, principals of schools, student groups, college officials, civic organizations and scout groups are being contacted repeatedly. Nearly all student nurses and student practical nurses throughout the state receive a lecture and a tour of an occupational therapy department. Groups of senior medical students receive informal demonstrations at Tulane Medical School. Mrs. Ruth Metcalfe, director of the occupational therapy department in the rehabilitation unit at the Tulane Medical School, has also given informal demonstrations to groups of women who are interested in seeing occupational therapy being applied.

During the ten day state fair in Shreveport, the Caddo School for Exceptional Children, with Mrs. Nancy Rachal as director of occupational therapy, had a booth which featured occupational, physical and speech therapies. Equipment and adaptations from all three therapies were displayed and explained. Colored slides were shown and commented upon. This group has been asked to provide a similar exhibit, with patients, at the state meeting of the Louisiana Medical Association in May. At the request of the planning committee for the "Conference on the Aging" held in New Orleans in March, an occupational therapy booth was provided. This booth created much interest.

Recently staff members of the Southeast Louisiana State Hospital were guests on a Sunday television show in New Orleans. The greater part of the discussion of the rehabilitation program was given by Mrs. Katherine Long, director of occupational therapy.

The state association is sponsoring an essay contest in a limited number of schools. This is a pilot project to determine whether such a contest should be held in a larger number of schools.

The visual aid committee is at present working on a portable, folding exhibit of pictures depicting each area of occupational therapy in Louisiana. Colored slides, to be used in conjunction with talks, are being assembled. The movie, "The OT Story," has been purchased by the association.

Much has been accomplished by the Louisiana Occupational Therapy Association since its organization April, 1956, but there is little time for looking backward, we must continue looking toward and planning for the future.

OFFICERS

President ..... Nancy Rachal, O.T.R.
Vice-President ..... Ruth Metcalfe, O.T.R.
Secretary ..... Ellen Heath Lindsey, O.T.R.
Treasurer ..... Beverly Slaton, O.T.R.
Delegate ..... Garnet Hines, O.T.R.

NEW YORK

Delegate-Reporter, Fred Erb, O.T.R.

Besides its regular monthly meetings of the Board of Management, the New York Occupational Therapy Association held five meetings during the past year, some of which were open to members only. Of these, one was a joint occupational therapy-physical therapy meeting which was well attended by about one hundred persons. Highlights of these meetings were an address by Dr. Svend Clemmesen, chief physician of the department of physical medicine and rheumatology, Municipal Hospital, Copenhagen, Denmark, and an account by Miss Barbara Neuhaus, O.T.R., who had just returned from a year in

Belgium on a Fulbright scholarship in occupational therapy.

Committees active during the past year were: bulletin, insurance, membership, special studies, scholarship, program, recruitment and volunteer. Of special interest is the report of the fund raising committee, which was launched in high gear by Captain Gertrude J. Murray, at the Cleveland conference. Four thousands tickets were distributed, and over two thousand were sold, including four hundred and fifty-six outside of the New York area. At a square dance held January 31, 1958, the round trip ticket to Denmark was won by Miss Lois Dwyer, R.N., of New York City, a nurse at the Payne-Whitney Clinic of New York. The success of this fund-raising venture was due largely to the work and enthusiasm of Captain Murray, who conceived the plan.

At its annual meeting the membership voted Honorary Life Membership to Mrs. Achilles H. Kohn, O.T.R., for her years of devotion to our profession and for her part in obtaining fifty thousand dollars from the Wollman Foundation.

After years of work, including countless meetings and reams of correspondence, the state reorganizational plan has been completed, with five districts in final agreement. Recognition of one New York State Association now awaits approval in October by the American Occupational Therapy Association.

Passport to Understanding will be the theme of the 1958 Institute-Conference. The conference planning committee under the chairmanship of Miss Frieda Behlen has been working tirelessly to provide a stimulating and rewarding experience for all who attend. The date is October 21, 22, and 23rd. The place, Hotel New Yorker.

We hope you will all be able to attend, and remember, New York City is a photographer's paradise, so bring your cameras and lots of film.

OFFICERS

President	Agnes Dick Ness, O.T.R.
First Vice-President	Ruth Smiley, O.T.R.
Second Vice-President	Ella Westerman, O.T.R.
Recording Secretary	Elizabeth Scully, O.T.R.
Corresponding Secretary	Kathryn Houdek, O.T.R.
Treasurer	Mrs. Alice Trei, O.T.R.
Assistant Treasurer	Gladys Rikert, O.T.R.
Delegate	Fred Erb, O.T.R.

MARYLAND

Delegate-Reporter, Marianne Catterton, O.T.R.

A memorable event for the Maryland Occupational Therapy Association was held immediately following the annual AOTA conference in Cleveland. At a cocktail party at the home of our president, Lucy Morse, Mrs. Marshall Price presented the Award of Merit plaque to Dr. Dunton who had not been able to attend the conference.

Our hats are off to our conscientious publicity chairman, Lora Dunetz, who has studied the ways of newspaper people. She has been successful in having all of our meetings announced in the newspapers, many of them over the radio, and has been able to get publicity on other association activities.

One of our meetings was directed toward interesting the allied therapists and aides working in our psychiatric hospitals. A workshop type of program was sparked by a panel led by a very competent psychiatric social worker, Mr. Harry Citron. Since it was thought that the program would be of interest primarily to those working in psychiatry, it was surprising and heartening to hear some of the lively remarks and discussions among therapists in other disability fields. This meeting was so successful it is expected to be followed by similar ones.

Last year our association contracted for a theatre-in-the-round evening with a local theatrical group. After several years of struggling with various fund-raising enterprises, selling theatre tickets seemed easy and much more dignified. The play was a good one and well done, so the evening at the theatre was a great deal of fun. Over and above that, the patrons' list contained some very prominent local names and provided an excellent means for bringing our association to their attention. When it proved financially successful, this method became a permanent fund-raising project. This, the second year, we were happy to find that the size of our patrons' list had increased.

OFFICERS

President	Lucy G. Morse, O.T.R.
Vice-President	Patricia Potter, O.T.R.
Secretary	Mary A. Shaw, O.T.R.
Treasurer	Lillian Chong, O.T.R.
Delegate	Marianne Catterton, O.T.R.

TEXAS

Delegate-Reporter, Lucile L. Lacy, O.T.R.

The Texas Occupational Therapy Association has a total membership of 106: 74 active, 8 associate, 20 state, and 4 students. The three districts in the state have grown and are now well established groups. Because of the long distances in the state, the groups have helped greatly to establish continuity in the work of the organization between the annual state meetings. Planned programs in each have been the basis for professional study and discussion. Through the districts, occupational therapy information has been disseminated to the public by newspaper, television, radio, and by personal appearances with various groups.

The two-day annual meeting was held in April at the Flying L Ranch in Bandera, Texas. The South Central Texas District was the host group. The program included discussions of interest to those working in the various disability areas. One session in group dynamics proved very stimulating to all. The informality of the ranch atmosphere lent itself to good group interaction.

The newsletter has been a means for calling attention to much national and state news. Special emphasis has been placed on AOTA membership. The association is pleased to have purchased its own duplicating machine this year.

Scholarship, both on district and state level, has been a *MUST* this year. One $175.00 scholarship was awarded to a student at Texas Woman's University in Denton, Texas. Funds available indicate that a similar one will be awarded this coming year. The Jesse H. Jones Foundation has made a commitment for $2,500.00 to be given in five installments over the next five years, that is, $500.00 each September, 1957-1962, for scholarships to occupational therapy students at Texas Woman's University.

OFFICERS

President	Irene Greer, O.T.R.
Vice-President	Hope Keeney, O.T..R
Secretary	Alice Amison, O.T.R.
Treasurer	Irene Hollis, O.T.R.
Delegate	Lucile L. Lacy, O.T.R.
Alternate Delegate	Rena C. Worthington, O.T.R.

Buy
From
Your
Journal Advertisers

O-P Craft

You'll see an exciting variety of crafts-wares for design and decoration. Appealing items to enrich your crafts interests at a low cost. Unlimited for creative effects. No charge for catalog.

Please Write

The O-P CRAFT CO. Inc. SANDUSKY, OHIO

THIS
BIG ILLUSTRATED
LEATHERCRAFT
CATALOG

There is no finer source of materials for Leathercraft projects of all kinds . . . . . easy-to-assemble kits to enable beginners to make billfolds, gloves, purses, belts and other attractive items . . . . top quality tooling and carving leathers for advanced craftsmen. Also complete line of Leathercraft tools, accessories, supplies and instruction books.

ATTENTION
METALCRAFT
HOBBYISTS

Here is a comprehensive illustrated catalog from which you can make your selection of aluminum and copper in sheets and shapes for many projects; copper, aluminum and brass foil for metal tooling; kilns, colors and kits for metal enameling; instruction books, tools and accessories for metalcraft of all kinds.

SEND TODAY FOR EITHER OR BOTH FREE CATALOGS

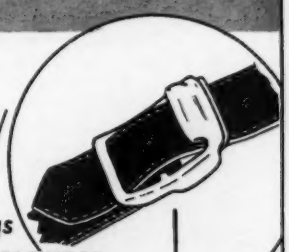
J. C. LARSON CO.

820 S. Tripp Ave., Dept. 8111
Chicago 24, Illinois

LEARN AT HOME — GEM MAKING

CUT GEMS . . . MAKE JEWELRY PIECES FOR FUN — FOR PROFIT! Start today . . . get acquainted with the most thrilling hobby ever devised — LAPIDARY. Learn to make expert, professional-type rings, bracelets, jewelry in your own home. SEND for our FREE 16-page booklet . . . detail data from the nation's leading suppliers to the trade. NO OBLIGATION write today to: GRIEGER'S, 1633 E.Walnut, Pasadena 25,Calif.

PARVA
Prongless Buckles



No Holes
No Prongs

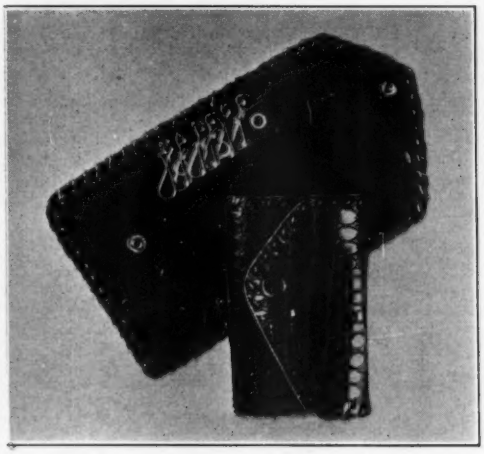
TRUE FIT, QUICKLY

This precision-engineered prongless buckle was specifically created for use where rapid — even single-handed adjustments are required. Exact SLIP-PROOF adjustment, and quick release are assured of leather, fabric or plastic straps!

PRESENT SIZES: ¼, ⅜, ⅜, ½, ⅝

for further information, write to

PARVA Buckle Company
2974 WHITNEY AVENUE, MOUNT CARMEL, CONN.



Just one of the 100 different items for your O.T. Dept. Original designs. Low prices. Send for catalog.

"Makers of the famous Golka Tipping Pliers and disposable Slim Tips." Makes your lacing work a pleasure.

ROBERT J. GOLKA CO.

400 Warren Ave.
Brockton, Mass.

EXER - DOUGH

for use in

Rehabilitation Centers—Hospital Clinics
Schools for Handicapped Children

Eminently suited in therapeutic exercises for the muscles of the fingers, hand, forearm, the shoulder girdle and scapula group.

YES, IT CAN BE AUTOCLAVED

In a multitude of treatment situations Exer-Dough will do the holding for you. It is superior to suction cups and often will replace "C" clamps, cut-out boards and other conventional means of "holding."

RETAIL PRICES

1 5"x5" Sheet (approximately ¼ lb. net weight) $2.00
10% discount on orders of 12 or more sheets.
To orders of one and two sheets only, add 10% for postage and postal insurance, unless remittance is included with the order.

AVAILABLE THROUGH

Abbey Rents—600 South Normandie Ave.
Los Angeles, California

Rehabilitation Products—2020 Ridge Ave.
Evanston, Illinois

J. A. Preston Corporation—175 Fifth Ave.
New York 10, New York

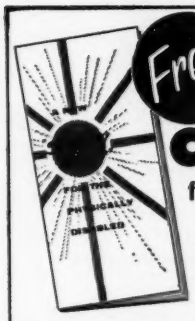
Jay L. Warren, Inc.—1247-49 Belmont Ave.
Chicago 13, Illinois

Exclusively processed by

EXER-DOUGH ENTERPRISES

J. G. Wiersma and Associates

P.O. BOX 425. ARLINGTON, CALIFORNIA



THE

Free FASCOLE CATALOG

for the Physically Disabled

A single source of supply to fill your every need when ordering self-help devices and personal hygiene articles for the physically disabled, including household aids for the disabled homemaker.

Now, with the help of the Fascole catalog and its new supplement, which list and illustrate over 200 items for the rehabilitation of the disabled and convalescents, you can simplify your ordering problems and at the same time be certain that you are paying the lowest prices available for articles of comparable quality. Fascole offers prompt, efficient mail order service and discounts are allowed to hospitals and recognized institutions on quantity orders.

All Fascole merchandise has been carefully selected to meet strict requirements of quality, workmanship and value. Each item is backed with the *guarantee* of a manufacturer with many years' experience in this very specialized field.

To get your *free* FASCOLE CATALOG just write: FASCOLE CORPORATION, Dept. A, 229 Fourth Avenue, New York 3, N.Y.

FASCOLE *Shopping Center* for the Physically Disabled

1st Step to BETTER ENAMELING

For Teachers, Students, Hobbyists, Professionals

Everyone appreciates the better results, the improved workmanship, the beautiful pieces you get with T C T Enamels. For 65 years, we have emphasized **quality, value and service** to enamelers . . . now offer over 150 shades of enamel colors in lump and powder plus, opalescent, crackle, glaze paint. separation enamel, threads liquid gold.

We also supply: Kilns, Findings, Metal Shapes, Chains, Trivets, Frames, Wire

NEW for Glass Decorators

We offer a full line of Ice Colors for firing on glass. **Write for complete information.**

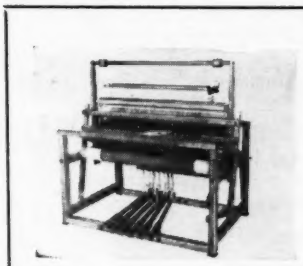
Write for FREE CATALOG

DEPT. OT

SINCE 1890

Thomas C. Thompson Co.

1539 Deerfield Road • Highland Park, Ill.



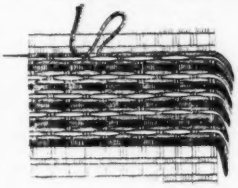
Weaving Looms Recommended for Therapy

Expertly designed to simplify operations, LECLERC looms provide a beneficial relaxation of body and mind through smooth, regular exercises. Models of various sizes.

Free catalogue on request.

Nilus Leclerc INC.

L'ISLETVILLE, NO. 21,
QUEBEC, CANADA



Rayonette Stole Magic

Available again. An Ideal craft for occupational therapy. Simple, interesting and fashionable. Used as a base in weaving stoles, afghans, baby blankets, hot pads, etc. Priced at 34c per yard in 24" width, and available by the 2 yard piece or 50 yard bolt. Also available in 40" width priced at 58c per yard, or 55c per full bolt. Send for swatch, instruction sheet and complete price list.

LEE ADVERTISING SPECIALTY CO.
9006 Joseph Campau, Detroit 12, Michigan

LEADING SPECIALISTS RECOMMEND

Thera-Plast®

The ideal, specially processed silicone rubber putty exercising agent for illnesses and injuries to bones, muscles, tendons and nerves.

STRENGTHENS:
- Fingers
- Hands
- Wrists
- Forearms

Full 2 oz. tin. At your surgical dealer. **$2.50**

For literature write:
THERA-PLAST CO.
154 Nassau St., New York 38, N. Y.

x-acto® inexpensive Handicraft Kit Packages

A wide assortment of inexpensive projects embracing five of the most popular X-acto handicrafts—Plexon Plastic Lacing, Indian Beadcraft, Suji Wire Art, Genuine Leathercraft and Bamboo and Wooden Stringing Beads.

Write for FREE Handicraft Brochure and details on Bulk Pack for Group Activity

LATEST PROJECT BOOKS
- Wood Whittling 25c
- Indian Beadcraft 25c
- Braiding & Weaving with PLEXON Plastic Lacing.... 25c
- Hobby Tools and How to Use Them 75c
- X-acto Catalogue 25c

X-ACTO, INC.
48-411 Van Dam Street
Long Island City 1, N. Y.

A Single Source for All your Craft Supplies!

Send for Free Copy
"ALL CRAFTS" CATALOG

SAX BROS

Get our NEW catalog No. 58, 102 big PAGES—Thousands of items. — Prices reasonable — Service COMPLETE and PROMPT, from our large stocks. Our goal is to fill EVERY craft need of the Occupational Therapist — No matter how unusual, or how large or small!!

Since 1910

LEATHERCRAFT
ENAMELING
WOODENWARE
METALCRAFTS
BASKETRY
CERAMICS
MOSAIC TILE
LAPIDARY
ART SUPPLIES
BEAD WORK
FELT CRAFT
and many others.

SAX-CRAFTS—Division of
SAX BROTHERS, INC.
1111 N. 3rd St.—Dept. OT—Milwaukee, Wis.

SILK—WOOL—RAYON—LINEN—COTTON—NOVELTY YARNS

20/1 and 20/2 Linen. 19 Beautiful Fast Colors on 4 oz. tubes.

3/2 and 10/2 Fast Colors. Mercerized Perle Cotton.

2/20 Weaving Worsted. 36 beautiful colors on 2-oz. tubes. For Warp and Weft.

8/4 Boil-Fast Carpet Warp —22 colors on ½ lb. tubes.

Approved by Veterans Administration U.S. Govt. Occupational Therapy Program.

We have a complete assortment of yarns for home and commercial weaving.

(Write for free samples)

CONTESSA YARNS Dept. C.W., Ridgefield, Connecticut

RAYON FLOSS AND CORDE YARNS

For Making Place Mats and Pocket Books

Send for Sample Card and Price List

CONCORDIA MANUFACTURING CO. INC.

P.O. Box 36, Central Falls, Rhode Island

A Complete Line of Ceramic Supplies

CLAY — BRUSHES
GLAZE — PATTERNS
MOLDS — KILNS
COLORS — SUPPLIES

FREE PERPETUAL CATALOG

When requested on your institution letterhead
Others please send $1.00

WILLOUGHBY STUDIO

407 East Florence Avenue — Inglewood 1, California

KNIFORK

Eating pleasure for the Handicapped

Lets patient cut and eat any food with 1 hand—SAFELY. Perfect for bed-tray meals. Scientifically made of ground and polished stainless steel. Specify right or left hand. Only $2.75 each, quantity prices on request.. Guaranteed. Order from —

MOORE KNIFORK CO.

PO Box 43065 • Los Angeles 43

For Treatment of
SPASTIC CASES • CEREBRAL PALSY • STROKE • POLIO
HAND INJURIES

GENERAL ELECTRIC COMPANY'S SILICONE

BOUNCING PUTTY

Does Not Harden • Lasts Indefinitely
Can Be Autoclaved

OCCUPATIONAL THERAPY

As A "Trial Order"—Send $2.00 For One $2.85 Jar

S. R. GITTENS, Sole Distributor

1620 Callowhill St., Philadelphia 30, Pa.

COMPLETE LINE OF QUALITY HANDICRAFT SUPPLIES

COLORS • LINKBELTS • METAL ENAMELING
RTISTS • CRAFTSTRIP • METAL CRAFT
• CRAFT BOOK • WOODEN BOXES
UPPLIES • BLOCK PRINTING
CRAFT • WOODEN PLATES
TS • ARTISTS SUPPLIES
AFT • CHIP CARVING
K • TEXTILE COLORS
• GLASS ETCHING
NG • LEATHERCRAFT

FREE CATALOGUE ON REQUEST

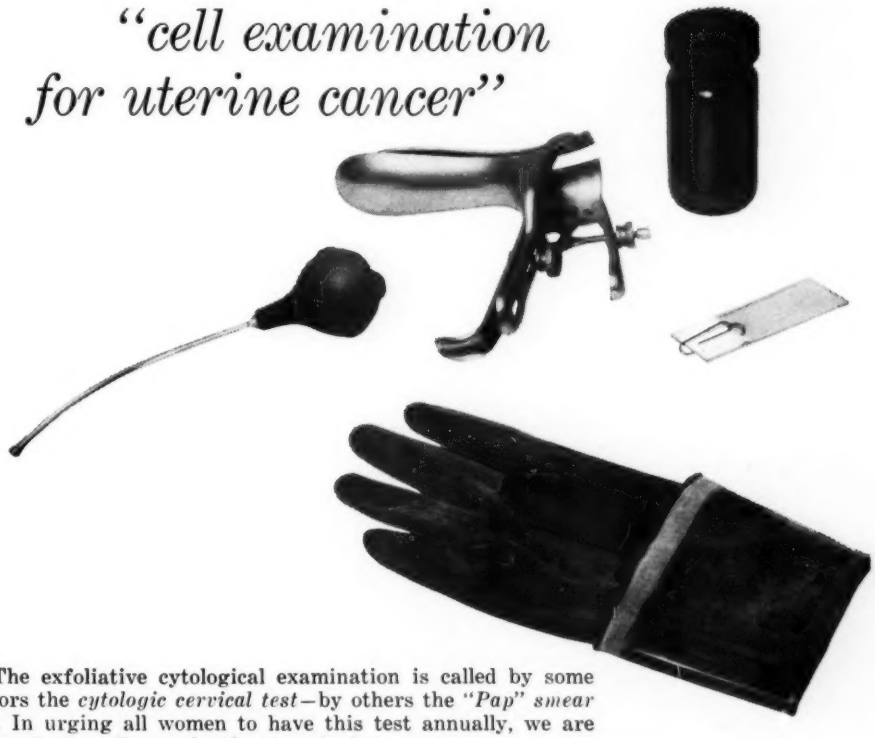
GAGER'S HANDICRAFT

1024 NICOLLET AVE.
MINNEAPOLIS, MINNESOTA

FEderal 5-6757

AN EXPERIMENT IN MEDICAL NOMENCLATURE INTRODUCING THE TERM:

"cell examination for uterine cancer"



The exfoliative cytological examination is called by some doctors the *cytologic cervical test*—by others the *"Pap" smear test.* In urging all women to have this test annually, we are calling it the *cell examination for uterine cancer.*

Here are our reasons:

Cytologic cervical test is a term which seems complicated to many women.

"Pap" smear test is simple, but women we have talked to find the word "smear" unpleasant and disturbing, and it may add to their anxieties about pelvic examinations.

Public relations advisors say that broadcasters and editors will dislike "smear"—and TV, radio and the press will be essential to the success of this educational project.

We have considered other terms but have at last agreed on *cell examination for uterine cancer* as the term which simply and accurately describes the keystone of this vitally important program.

This test can help save thousands of women each year. In many parts of the country it is becoming widely accepted as a part of a routine checkup. As fast as county medical societies approve, our local Units will urge women to go to their physicians annually for a *cell examination for uterine cancer.*

AMERICAN CANCER SOCIETY

®

IDEAS BLOSSOM OUT WITH

Staley's Sta-Flo® LIQUID STARCH

AND PRANG® POWDER TEMPERA

FINGER PAINTING IS NOW SIMPLE AS A. B. C.!

A

Wet shelf paper thoroughly on both sides. Place shiny side up and smooth out wrinkles.

B

Pour one teaspoon of starch on paper. Add ½ teaspoon of Prang Powder Tempera Color and work mixture evenly across paper.

C

You use all parts of hands for different effects — palms, finger tips, nails and heels of hands.

The happy discovery of mixing Staley's STA-FLO Liquid Laundry Starch with PRANG Powder Tempera Color creates a most stimulating and economical color mixing medium which has been a joy to countless teachers everywhere.

INSTANT COLORS! . . . Colors become alive with the first touch of Powder Tempera and Liquid Starch . . . so easy to blend and smooth to apply.

DRIPLESS COLORS! . . . Yes, colors so mixed will not drip off the brush and will wash out of clothing as easy as starch alone!

Provides endless variety for every creative activity from elementary free expression to advanced Harlequin Arts.

SEND FOR

our very newest Program Building Idea Sheets.

IT'S FREE!

a THE AMERICAN CRAYON COMPANY · SANDUSKY, OHIO · NEW YORK (Dept. OT-43)

THE AMERICAN JOURNAL of OCCUPATIONAL THERAPY

OFFICIAL PUBLICATION OF THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

Vol. XII, No. 4, Part II 1958 July-August

O.T. Bulletin

TABLE *of* CONTENTS

ARTICLES

DIVISIONS

Copyright 1958 by the American Occupational Therapy Association
New York 19, New York, Published bi-monthly.

This is Part II of a two-part issue.

Photographed at the Nassau Straw Market, one of the tourist attractions of the Bahamas.

IF you are like most couples, the years after forty-five can be as rewarding as any in your lives. You've raised the children, seen them settled. Now you can look forward to enjoying many things you deferred while the family was growing up—to pleasant years made secure and independent by a lifetime of saving. How wise to protect that independence by investing part of your savings conservatively in safe, sure U. S. Savings Bonds! The return is good—3¼% at the bonds' maturity. And you can increase your security so easily by buying more Series E Bonds regularly where you bank or automatically through the Payroll Savings Plan at work. Or, if you'd rather have your interest as current income, order Series H Bonds through your banker. The time to do it? Now. When financial independence counts, count on U.S. Savings Bonds!

The U. S. Government does not pay for this advertisement. It is donated by this publication in cooperation with the Advertising Council and the Magazine Publishers Association.

A Single Source for All your Craft Supplies!

Send for Free Copy
"ALL CRAFTS" CATALOG

SAX BROS

Get our NEW catalog No. 58, 102 big PAGES—Thousands of items. — Prices reasonable — Service COMPLETE and PROMPT, from our large stocks. Our goal is to fill EVERY craft need of the Occupational Therapist — No matter how unusual, or how large or small!!

Since 1910

LEATHERCRAFT
ENAMELING
WOODENWARE
METALCRAFTS
BASKETRY
CERAMICS
MOSAIC TILE
LAPIDARY
ART SUPPLIES
BEAD WORK
FELT CRAFT
and many others.

SAX-CRAFTS—Division of
SAX BROTHERS, INC.
1111 N. 3rd St.—Dept. OT—Milwaukee, Wis.

PROFESSIONAL "KNOW-HOW" FREE ON FASCINATING PROFITABLE HOBBY

LEARN AT HOME — **GEM MAKING**

CUT GEMS . . . MAKE JEWELRY PIECES FOR FUN — FOR PROFIT! Start today . . . get acquainted with the most thrilling hobby ever devised — LAPIDARY. Learn to make expert, professional-type rings, bracelets, jewelry in your own home. SEND for our FREE 16-page booklet . . . detail data from the nation's leading suppliers to the trade. NO OBLIGATION write today to: GRIEGER'S, 1633 E.Walnut, Pasadena 25,Calif.

Everything for the Handweaver

HIGH QUALITY *Lily* HANDWEAVING YARNS AND SUPPLIES

COTTONS • WOOLS • HOMESPUNS
LINEN • METALLICS • CHENILLES
NOVELTY YARNS

Looms, including the Leclerc Folding Loom
Warping Frames
Bobbin rocks and winders
Table reels Tension boxes

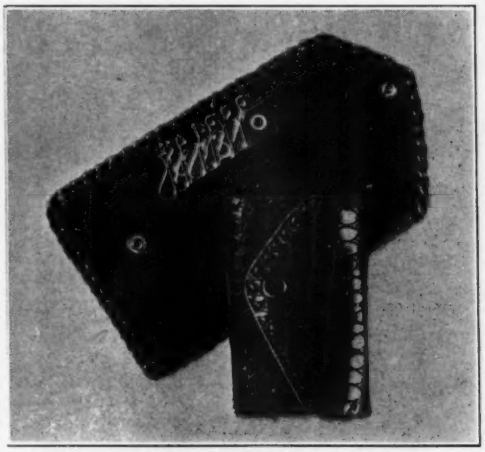
PROMPT SHIPMENTS

Send $1.00 for complete color cards. This $1.00 can be applied to your next order of $10.00.

Write today for free catalog and current price list

Order all your handweaving supplies from the Handweaver's Headquarters

LILY MILLS COMPANY
Dept. HWN, Shelby, N. C.



Just one of the 100 different items for your O.T. Dept. Original designs. Low prices. Send for catalog.

"Makers of the famous Golka Tipping Pliers and disposable Slim Tips." Makes your lacing work a pleasure.

ROBERT J. GOLKA CO.

400 Warren Ave.
Brockton, Mass.

Paragon®
NEEDLECRAFT

Headquarters for Creative Needlework Therapy Materials

- **Stamped goods**
- **Rug Yarn**
- **Embroidery threads**
- **Needlepoint**
- **Tapestry Yarn**
- **Metallic Yarns**

Therapists who prefer **creative** needlework projects invariably turn to **Paragon.** Whether **you** seek materials for simple short term or long term projects . . . for male or female patients . . . **Paragon's** all-inclusive line will fill your need. Many projects come in complete kits. All Paragon Needlecrafts are made of finest materials. Threads are color-fast. Easy, step-by-step, instructions guarantee gratifying results.

FREE: NEW STEP-BY-STEP FOLDER TEACHING ALL POPULAR EMBROIDERY AND NEEDLEPOINT STITCHES

For complete price list and catalog please write:

PARAGON NEEDLECRAFT,
Dept. O.T.,
Office and Plant:
511 East 72 St., New York 21, N. Y.
Showroom: 385 5th Ave.

EXER - DOUGH

for use in

Rehabilitation Centers—Hospital Clinics
Schools for Handicapped Children

Eminently suited in therapeutic exercises for the muscles of the fingers, hand, forearm, the shoulder girdle and scapula group.

YES, IT CAN BE AUTOCLAVED

In a multitude of treatment situations Exer-Dough will do the holding for you. It is superior to suction cups and often will replace "C" clamps, cut-out boards and other conventional means of "holding."

RETAIL PRICES

1 5"x5" Sheet (approximately ¼ lb. net weight) $2.00
10% discount on orders of 12 or more sheets.
To orders of one and two sheets only, add 10% for postage and postal insurance, unless remittance is included with the order.

AVAILABLE THROUGH

Abbey Rents—600 South Normandie Ave. Los Angeles, California

Rehabilitation Products—2020 Ridge Ave. Evanston, Illinois

J. A. Preston Corporation—175 Fifth Ave. New York 10, New York

Jay L. Warren, Inc.—1247-49 Belmont Ave. Chicago 13, Illinois

Exclusively processed by

EXER-DOUGH ENTERPRISES

J. G. Wiersma and Associates

P.O. BOX 425. ARLINGTON, CALIFORNIA

1st Step to BETTER ENAMELING

For Teachers, Students, Hobbyists, Professionals

Everyone appreciates the better results, the improved workmanship, the beautiful pieces you get with T C T Enamels. For 65 years, we have emphasized **quality, value and service** to enamelers . . . now offer over 150 shades of enamel colors in lump and powder plus, opalescent, crackle, glaze paint. separation enamel, threads liquid gold.

We also supply: Kilns, Findings, Metal Shapes, Chains, Trivets, Frames, Wire

NEW for Glass Decorators

We offer a full line of Ice Colors for firing on glass. **Write for complete information.**

Write for FREE CATALOG

DEPT. OT

SINCE 1890 TCT

Thomas C. Thompson Co.

1539 Deerfield Road • Highland Park, Ill.

SILK—WOOL—RAYON—LINEN—COTTON—NOVELTY YARNS

20/1 and 20/2 Linen. 19 Beautiful Fast Colors on 4 oz. tubes.

3/2 and 10/2 Fast Colors. Mercerized Perle Cotton.

2/20 Weaving Worsted. 36 beautiful colors on 2-oz. tubes. For Warp and Weft.

8/4 Boil-Fast Carpet Warp —22 colors on ½ lb. tubes.

Approved by Veterans Administration U.S. Govt. Occupational Therapy Program.

We have a complete assortment of yarns for home and commercial weaving.

(Write for free samples)

CONTESSA YARNS Dept. C.W., Ridgefield, Connecticut

LEADING SPECIALISTS RECOMMEND

Thera-Plast®

The ideal, specially processed silicone rubber putty exercising agent for illnesses and injuries to bones, muscles, tendons and nerves.

STRENGTHENS:
- Fingers
- Hands
- Wrists
- Forearms

Full 2 oz. tin. At your surgical dealer. $2.50

For literature write:

THERA-PLAST CO.
154 Nassau St., New York 38, N. Y.

KNIFORK

Eating pleasure for the Handicapped

Lets patient cut and eat any food with 1 hand—SAFELY. Perfect for bed-tray meals. Scientifically made of ground and polished stainless steel. Specify right or left hand. Only $2.75 each, quantity prices on request.. Guaranteed. Order from—

MOORE KNIFORK CO.
PO Box 43065 • Los Angeles 43

JUST THE THING YOU WANT

Have a copy of Hammett's Catalog handy . . . it lists and illustrates the latest in occupational therapy materials and supplies. It's free!

LOOMS
Hand or Foot Power

WEAVING MATERIALS
Rug Roving, Cotton Yarn
Carpet Warp, Rug Yarns

BASKETRY MATERIALS
Reed, Raffia, Cane
Wooden Bases and Trays
Corkcraft

ART MATERIALS
Leather and Tools
Books of Instruction

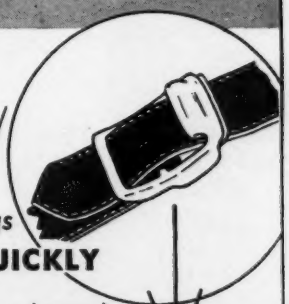
WRITE FOR YOUR FREE OCCUPATIONAL THERAPY CATALOG TODAY!

J. L. HAMMETT CO.

Educational Materials Since 1863

306 Main Street **Cambridge, Mass.**

PARVA
Prongless Buckles



No Holes
No Prongs

TRUE FIT, QUICKLY

This precision-engineered prongless buckle was specifically created for use where rapid — even single-handed adjustments are required. Exact SLIP-PROOF adjustment, and quick release are assured of leather, fabric or plastic straps!

PRESENT SIZES: ¼, 5/16, ⅜, ½, ⅝

for further information, write to

PARVA Buckle Company
2974 WHITNEY AVENUE, MOUNT CARMEL, CONN.

Speed progress in ADL

Patients with upper extremity disabilities gain self-reliance with these OT designed products. They speed the return of muscular function and promote and encourage individual self-care—ideal for hemiplegic, quadriplegic, post polio patients, and many others.

Tomac Wheel Chair Table

TOMAC WHEEL CHAIR TABLE

With virtually unlimited adjustment possibilities, the Tomac Wheel Chair Table is ideal for work, eating or recreation. Unsurpassed for strength—it's sturdy enough to even support an electric typewriter. In an extreme raised position (10″), it's ideal for patients requiring almost complete arm support. Also tilts up to 35°.

Fits any make wheel chair easily and quickly by secure spring clamps. No space is lost between the double-tops for cumbersome raising devices. Extra-large top is 28″ x 28″ with 16″ x 8″ cut-outs.

No. 5215—Wheel Chair Table, ⅜″ plywood top, each **$39.50**

No. 5215A—Same, except ⅛″ Masonite top, each **37.50**

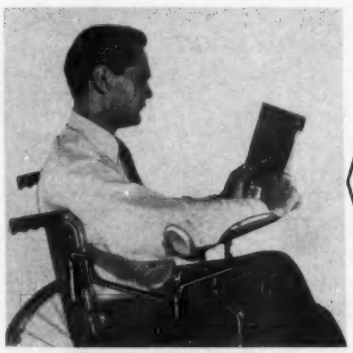
ARM SLING SUSPENSION

Helps prevent deformity and encourages activity. Excellent support for patient's arm to facilitate self-feeding, exercising and ADL.

Fits any tubular wheel chair with quickly installed bracket. Overhead support rod easily removed when sling is not in use. Sling assembly is adjustable to any position along overhead stainless steel rod. Comfortable leatherette slings adjust to any patient—adult or child.

No. 496-993-1—Arm Sling Suspension, each **$12.50**

Arm Sling Suspension



Ball Bearing Feeder

BALL BEARING FEEDER

Assists the patients not only in self-feeding, but in many other necessary Activities of Daily Living. This feeder (Warm Springs' type) works on the principle of balance and gravity elimination by means of friction-free ball bearings. Patient can feed himself, write, read or paint with minimum effort.

All steel except for aluminum trough. Over-all dimensions when folded, 15½″ long, 3½″ high, 4½″ wide. Weighs 2 lbs. Specify for right or left hand.

No. 5220—Ball Bearing Feeder, adult **$37.50**

No. 5221—Same, but with Adjustable Chair Bracket for reclining wheel chairs **50.00**

No. 5222—Ball Bearing Feeder, child **37.50**

Order these Occupational Therapy aids and other rehabilitation needs from:

Rehabilitation Products

A Division of American Hospital Supply Corporation, 2020 Ridge Ave., Evanston 22, Illinois, **Dept. 24**

Regional Sales and Distribution Centers

ATLANTA • Chamblee, Ga.
CHICAGO • Evanston, Ill.
COLUMBUS • Columbus 6, Ohio
DALLAS • Dallas 19, Texas
KANSAS CITY • N. Kansas City 16, Mo.
LOS ANGELES • Burbank, Calif.
MINNEAPOLIS • Minneapolis 12, Minn.
NEW YORK • Flushing 58, N.Y.
SAN FRANCISCO • South San Francisco, Calif.
WASHINGTON • Washington 18, D.C.

THE AMERICAN JOURNAL

of

OCCUPATIONAL THERAPY

Official Publication of the American Occupational Therapy Association

July-August 1958 Vol. XII, No. 4, Part II

Digest of Speeches from the American Occupational Therapy Association Conference

October 21-25

Eleanor Clarke Slagle Lecture

POWERFUL LEVERS

In Little Common Things

RUTH W. BRUNYATE, O.T.R.*

PREFACE

Madam president, occupational therapists and guests. It is with great pride, an overwhelming sense of inadequacy and profound humility that I accept the award you have conferred upon me. It is strange how small one feels in perhaps his biggest hour.

Worthiness for such an honor is never singly earned. An occupational therapist is, after all, merely a tool through which the doctor treats his patient. The value of the therapist can be judged only on the soundness of his contribution to treatment—for this is the culmination of his professional training. The therapist who participates in the administrative phases of a treatment program is again a tool through which the patient receives his treatment. The value of an administrative therapist can be judged only by the extent to which he is able to mold professional knowledge with sound business practice in such a way as to hold the patient in true perspective—for this is the culmination of his non-professional training.

These values are learned through formal education and experience but above all through the inspiration of others. I would, therefore, acknowledge the three people beyond my own family who have most affected the development of my abilities: Miss Helen S. Willard, Doctor Winthrop M. Phelps and Mr. Christopher H. Wiemer. Under Miss Willard's guidance I developed my philosophy of occupational therapy and my faith in my profession. Under Dr. Phelps' leadership I have developed my philosophy and techniques of treatment of the cerebral palsied and a concept of education as a continuing process based on simplicity, honesty, patience and diligence in the approach to complex problems. Under Mr. Wiemer's counsel I am beginning to learn the value of the individual in the ordered structure of the treatment unit, and a faith in oneself to see that value, to nurture it and direct it.

You have given me a very beautiful gift which I shall always treasure. I thank you each individually and pray that the hours of deliberation and the final thoughts presented here may be worthy of your trust.

FOREWORD

Forty years ago, on September 3, 1917, the first annual meeting of the National Society for the Promotion of Occupational Therapy was held in New York City. The meeting was called to order by the vice-president, Mrs. Eleanor Clarke Slagle. Who was this woman leading a pioneer group dedicated to a new profession? Occupational therapists who were active prior to 1942 had the privilege of knowing her. Some had met her, others knew her intimately. But for those who knew her not at all we would like

*Director of occupational therapy and administrative assistant, Children's Rehabilitation Institute, Reisterstown, Md.

to review her life, that each may understand why an award has been established to perpetuate her memory and why we value our Slagle heritage.

Eleanor Clarke Slagle was born just eighty-one years ago this October 13th in Hobart, New York.[2] Her brother was one day to become a prominent United States Senator from their native state. Mrs. Slagle was educated by tutors, then attended Claverack College, summer school of Columbia University and graduated from the Chicago School of Civics and Philanthropy. Here, as early as 1908, and largely through the inspiration of Julia Lathrop and Rabbi Harris, a course in invalid occupation was offered to attendants and nurses from hospitals for the insane. Dr. Adolf Meyer, professor of psychiatry at Johns Hopkins Hospital, gave continued advice and encouragement to the course.

Ruth W. Brunyate, O.T.R., Eleanor Clarke Slagle lecturer for 1957.

In 1913, when the Henry Phipps Psychiatric Clinic of the Johns Hopkins Hospital was opened, Mrs. Slagle became the director of occupational therapy. This position she continued to hold until 1917 when she became director of the Henry B. Favill Memorial School in Chicago. She returned to New York in 1922 to become director of occupational therapy of the New York State Hospital Service to which she devoted her energies until her death.

In March of 1917 at Consolation House, Clifton Springs, New York, the National Society for the Promotion of Occupational Therapy, forerunner of the American Occupational Therapy Association was founded. Incorporation papers were drawn and later signed by five people, two of whom, Dr. Dunton and Mrs. Slagle, are familiar to even the youngest of our present members. Mrs. Slagle became vice-president in 1919, president in 1920 and was secretary-treasurer from 1922 to 1937.

When she resigned in 1937 she retired to Tarrytown, New York, but continued her work in the state program where she established the practice of holding annual institutes for chief therapists to discuss problems and review new methods. She, in a sense, pioneered the very type of conference that we have only this year perfected. The last ten years of her life were complicated by a heart problem which was greatly taxed by a fall and back injury in 1940. Her insistence on continuing to practice her profession undoubtedly contributed to her death on September 18, 1942.

Reports of the early meetings of our Association tell us much of Mrs. Slagle and of the spirit which fostered our early development.[3] Forty years ago at our first annual conference the treasurer noted receipts of $109, expenses of $72.36 and an indebtedness of $150 to the lawyer for the cost of incorporation. The Society numbered 39 members of whom 26 attended this first meeting to enjoy a program including papers entitled, "Comparative Methods of Hospital Teaching," "Arts and Crafts in Medicine," and "The Teacher in Occupational Therapy." A review of patients followed and is notable, for it presented a depressed patient and an apparent case of paralysis, thus contradicting the now popular belief that early interests were devoted only to psychiatry. Finally a banquet was announced with great enthusiasm and later reported with equal interest, though Dr. Dunton tells us that it was a very sad occasion, for only three people appeared at Keen's Chop House to bolster their spirits and show their faith in a future profession. One of the three, of course, was Mrs. Slagle.

At the second annual meeting of the National Society for the Promotion of Occupational Therapy, September 2-4, 1918, in New York, Mrs. Slagle again played a prominent role and, again as vice-president, she presided. The treasurer reported a balance of $38.73 and noted that with the aid of a loan of $30 the costs of incorporation had been paid, for the lawyer was growing impatient. He also noted there was owing this

Society $64 in unpaid dues.[4] (Perhaps we have inherited some early weaknesses?) Twenty-five members attended this meeting and heard papers on "The Problems of the Invalid Occupations in War Hospitals," "The Principles of Occupational Therapy," and "The Remuneration of the Teacher." The word "teacher" in the early literature refers to the one who teaches the patient, thus the therapist. The speaker here suggested that his topic was untimely "since more than half the world is giving its all in sacrifice,"[5] but continues that we are assured a "laborer is worthy of his hire." The topic initiated much discussion and the consensus was that the average salary for the occupation teacher seemed to be from forty to fifty dollars a month with maintenance. The salaries offered for re-construction aides averaged $1350 for home service, $1500 for head aide with ten assistants, and $1800 for supervisors. Post-depression graduates will note how this compared with their initial salaries of $1300 with maintenance.

Another note of interest is Mrs. Slagle's comment on training for occupational therapy. She stated that after considerable experience the speaker felt that two months of crafts training and three months of practice teaching in hospitals made an ideal arrangement for a short course. The candidate should have college education or its equivalent in other experience.[6]

The third annual meeting was held September 8-11, 1919, in Chicago at the Favill School, probably the first of all occupational therapy schools. The Favill School had for three years been housed by Hull House and the renowned Jane Addams greeted the convention and congratulated the Society "because you are really the vanguard on the line of philanthropic effort and you are beginning at the bottom as all great social experiments have always done."[7]

At this meeting Mrs. Slagle was elected president and so formally began her many years of leadership in our profession. As time goes by fewer therapists will be able to recall her personality, for fewer will have known her. Future therapists will instead have to do as we have done, turn to her letters, the minutes of meetings in which she participated and the memories of her friends to learn of the heritage she left to them. They must read of her dominant personality, her sense of humor, her abiding interest in children, her ability to be outstanding in any situation, her dignity and handsome manner of dress and carriage, her astute mind, and her ability to rise above adversity. These traits of character were forceful factors in her influence on the growth of our profession as she moved from office to office and helped determine the framework of our present American Occupational Therapy Association.

But Mrs. Slagle's greatest contribution was to the practice of occupational therapy, not to its organization. This phase of her work is less known perhaps because it is a more personal thing or because it is less tangible and more difficult to study. She was tremendously interested in students, in their education and growth and in the direction of their work that they might share her enthusiasm in patient treatment. To perpetuate her memory we will now turn to this her greatest heritage and, using her own writings as a point of departure, will incorporate some of our own thoughts on student training and its meaning to the individual student, to the director of his course and to the members of this Association.

Ae we begin this third Slagle lecture we would use her own words from the presidential address of 1920, "this happens to be my turn and, like the measles and mumps or various and numerous other labelled states of mind or body, you wish me well, and hope it will be over soon."[8]

"POWERFUL LEVERS—IN LITTLE COMMON THINGS"

Clinical training is an outmoded phrase. We now speak of student affiliation and indeed date ourselves when we fail to do so, yet the original phrase has meaning for us as a review of definitions will show. The dictionary defines "clinic" as "medical instruction at the bedside of the patient," and defines the world "train" as "to bring to a required standard of knowledge or skill to give education by instruction and discipline." Since education is "the systematic development or cultivation of natural powers by inculcation or example," the concept of clinical training immediately implies apprenticeship. In clinical training one is assigned to a clinic to apprentice or "serve in order to learn." Initially then our choice of the phrase "clinical training" was to describe that period of the professional education devoted to serving another that through instruction and discipline one would cultivate his own natural abilities.

More recently we have adopted the phrase student affiliation. A student is "a person engaged in a course of study especially an advanced scholar—one who closely examines or investigates." To affiliate is "to receive on friendly terms, associate with—to adopt as a child." And here we would better cease to quote for the dictionary goes on to say "to associate with, usually reflexively or passively,"[9] and we know of few training experiences which could be called passive. Our new phrase "affiliate" has, we believe, a meaning too often overlooked, namely, to re-

ceive on friendly terms—to adopt. Our traditional concept of clinical practice is usually in terms of an assigned period spent in each of four or five clinics in which the student bridges the gap from the classroom to the job, a period of trial under supervision, a period in which to practice all that has previously been theory, thus the climax of academic experience.

We would think of student affiliation in a far broader sense for we believe that it is a period of transition to a whole new way of life. In an early paper Mrs. Slagle said, "A study of the greatest teaching personalities is a revelation of the powerful levers they found in little common things to lift their pupils up and out into a fuller life, and it is to the study of such methods that the most successful teacher will look for help."[10] Mrs. Slagle was using this thought to describe a therapist's work with a patient for she again used the word "teacher" as we now use the word "therapist." We feel, however, that this same key to success in treatment is the real key to success in teaching and indeed even the key to success in the performance of all of our daily tasks.

The nine month period of clinical affiliation must be a period of time in which the student gains far more than the opportunity to put his new knowledge into practice. It must be above all else a period of time in which those who teach "lift the student up and out and into a fuller life." Those who direct the student do not perform their roles successfully until they place the development of the individual in true perspective—above the importance of interpreting the theory and practice of occupational therapy in a particular disability area. The student who enters the affiliation period just to become proficient in applying his professional skills fails miserably if he does not first develop the personality and character through which the professional skills receive their most potent meaning.

Too often we forget that the majority of occupational therapy students are gaining their college education and professional training at one and the same time. We try to graduate a professional tool for the doctor and lose sight of the basic need of all college students to find time to grow as they learn.

The period of affiliation is, we feel, the most important of all educational experiences for it is true education lifted beyond the framework of what is purely academic. It is a practical experience and a period of transition in which the student must gain the ability to live as an independent person—which is to say he must begin to jell his own philosophy of life, of work and of his profession.

Sometimes those who teach are so preoccupied in following the essentials set down by the American Medical Association that they fail to see that a student is also trying to live with himself and others. Each affiliation must have a "well-defined program to interpret the function of occupational therapy in its own area or type of service,"[11] but of more permanent value is the atmosphere and personalities through which this program is introduced. People are more important than things. Personalities are remembered long after course content is forgotten. In the clinical field even more than in the formal setting of the professional school, the character of the teacher makes a lasting impression, for here there is daily contact under all sorts of conditions, here there is a sharing of responsibilities, here there is an apprenticeship. The importance of the individual therapist in training a student in any one affiliation will be notable to you if you will but for a moment recall your own affiliations. It is not true that even those of you who have been out of school for "generations" can recall to this day the individual personalities of those who counselled you in each affiliation while you may have forgotten some once favored classroom professor. We remember the things we do rather than the things we hear about. We remember the things we see rather than the things about which we are told. We remember the things we feel rather than those we experience only through others.

For these reasons therapists involved in student affiliation programs must evaluate themselves as well as their staffs and programs with utmost care. We should have a very sound philosophy of student training if we are to accept the challenge and privilege of student education. This philosophy must enable us to give to the student through our own example an opportunity to develop a wisdom, an acceptable law by which he will live his adult life. It must give him, too, an appreciation for and thus the desire to share our own way of living, of working, of practicing our profession. If we teach these things we are successful in student training. As a guide to teaching them we would now suggest some factors so common and so little that they have a tremendous effect upon us all. Let us enumerate a few as an index for individual thinking.

The ability to make one's way alone. College is the time when a young person makes the transition to independence—independence of action and of thought. It is the time when personality is developed and character molded, the time when he must realize that he becomes an adult and must make his way alone. This transition is a difficult one and yet must occur while

the student is under the stress of study. All such experiences are learned under stress, for this is when one uses the ultimate of his own discipline, and discipline is innate to the process of education. If a student learns to habituate himself to his environment he will have matured tremendously, for his environment is only temporary and will always change as long as he shall live. If he learns to adjust himself to living with his own kind and with those who differ in every way he will achieve some measure of both success and happiness.

The acceptance of things you do not condone or choose. Along with growth in independence must come the realization that things cannot always go according to one's own choosing. This is perhaps the most difficult of all experiences which occur when youth accepts adulthood, and many individuals of senior years bring unhappiness to themselves or others through never having understood the lesson. Students have so recently acquired freedom from the dictums of others that they have a false security in the justifiability of their own ideas and wishes, and so resent having to accept again a control even in this new form—self discipline and tolerance. Sir William Osler, the famous physician, once said, "Things cannot always go your own way. Learn to accept in silence the minor aggravations, cultivate the gift of taciturnity and consume your own smoke with an extra draught of hard work, so that those about you may not be annoyed with the dust and soot of your complaints."[12] This attitude once acquired becomes ingrained and is the fountain from which we gain our ability to understand others and so to be comfortable in our work with them. It must become part of an individual before he is able to follow direction and share departmental responsibility and it must be so inherent in his personality that it is no longer a conscious thing if he is to be successful in the direction of others.

A willingness to listen. This is another trait which must develop in college years and crystallize at the time of student affiliation. Too often freedom from the classroom, assigned reading and prearranged group participation gives an exaggerated feeling of importance and fosters an eagerness to express oneself and a restlessness which leaves no time for reflection. New found information is assumed to be seasoned knowledge which the owner is impatient to share—or at least reiterate. Quietness or meditation and attentiveness are scorned as the shy attributes of the inexperienced and are accepted only with embarrassment unless the student is given the opportunity to practice them and encouraged to realize their value. Today's students are being groomed for a world geared to the pace of group dynamics and the workshop exchange of ideas. They will lose half the value of participating if they have not first learned to listen. Sometimes it would appear we are all afraid of a moment of silence.

A willingness to seek advice. Perhaps this is felt to be a feminine trait yet some of the biggest men in history personify it. It begins again in little things, the recognition that we cannot know everything, that we are human and therefore even forget part of what knowledge we have acquired. One must learn to turn to others when the need arises but to turn cautiously and select our source wisely, then meld the counsel with our own experience and thus accept it as advice, not as a directive or decision. Mrs. Slagle once wrote to a friend, "I seek advice—I also seek to please."[13] Some would say this is a contradiction and that she was in a sense just trying to see-saw by herself and was thus running from the seat at one end to that at the other. Others would feel she was straddling an issue, thus standing over the fulcrum and so successful in see-sawing alone. We feel that the two thoughts frequently go hand in hand, for seeking the thoughts of others often results in giving pleasure to both of the individuals involved. At any rate there seldom, if ever, comes the time when we arrive at the point of never needing the help of others.

An ability to appreciate the commonplace. An occupational therapist will always work with people from all walks of life. Frequently he is pulled far from his own native environment and thrown into the problems of varied standards of living. Sometimes the sordid, the filthy, the crude come hand-in-hand with illness and disability and overwhelm the inexperienced. The ability to appreciate the commonplace, to note a touch of beauty in the midst of squalor or be aware of tenderness even in frugal living, this is the trait that refreshes and strengthens the individual as he is introduced to the ways of others. Osler once said, "Nothing will sustain you more potently than the power to recognize in your own humdrum routine as perhaps it may be thought, the true poetry of life—the poetry of the commonplace, of the ordinary man, of the plain, toilworn woman, with their loves and their joys, their sorrows and their griefs."[14]

The ability to retain the buoyance of youth. The young have a wonderful zest for living which carries them through many a difficult hour. Unfortunately, as we take our place in the working world we gradually lose that enthusiasm, that eagerness and spontaneity. The student who learns to modify it yet retain it will be well

repaid. True, the exuberance and clumsiness of the puppy, particularly the big puppy, is humorous but not continuously desirable nor is it compatible with the dignity of maturity. However, who will deny the strength derived from the ability to rebound after rebuff, or the desire to adventure after mishap—and are these qualities not rooted in buoyance and vivacity?

An understanding of the value of time. Our modern world is time conscious and we are keyed to schedules and to a rapid pace, that we may accomplish the utmost immediately. We know a doctor who mourns that people no longer have time to be sick, nor to get well. He says that we used to crawl into bed and suffer our colds for four or five days but now must have a shot of this or a dose of that to stay on our feet. This trend is infectious and our students soon catch the disease. We must, through our own example, give them a truer concept of the value of time. Each day is a very real and integral part of one's life, for each individual is but the sum total of each day's experience. The student, busy with each affiliation, is keenly aware of blocks of time—four weeks here, eight weeks there—and prone to work through those blocks. If he will pause to realize that that which he adds to each day becomes the sum total of all his days, he will build a far better life. This is particularly true if he thinks he does not like the area to which he is currently assigned and is anxious to get on to another disability area. Someone has said, "Time is not always something to beat, it is also something to linger through and enjoy."[15] If we check off the days, we lose time, if instead we take each in turn and add to the day, we profit.

A realization that privilege is bound in duty. Traditionally as one moves up in status to more responsible positions he is granted more privileges. Those who are just learning the structure of an institution and the relative rank of services and positions frequently see the privileges that go with increased rank and perhaps even envy those who have found them. It is again at the student level that we must begin to realize that privilege and duty are closely interrelated. The apparent freedom of hours, of expression, of entrance and exit, carry a duty which should outweigh the privilege. One of the early members of the Dupont dynasty taught his sons that "no privilege exists that is not inseparably bound to a duty."[16] Privilege must be recognized by the one who receives it, must be guarded, never flaunted, must be doubly repaid through the sense of obligation that others in turn may respect it.

An equanimity of mental and moral outlook. Each student has lived through years of counsel from his elders, his family, his minister, his professors, but there comes a time when he must realize that the problems of the great moral issues of his time are now his own to solve. Many of our occupational therapy students attended college in areas close to their own homes, even perhaps commuting from their family residences. For them the affiliation period is the first real break, particularly if they are not receiving maintenance, for now they find themselves in a strange city completely independent. Those of us who are busy with such a student in duty hours frequently forget that he may be experiencing for the first time the pressure of living the moral code that he has inherited. We must somehow help him to see that while mores change, fundamentals do not. This is the time in which an innate sense of the fitness of things becomes his own possession rather than a hand-me-down. If he gains an appreciation of the good which is inherent in every fellow being whatever his station in life, and a commiseration for the evil again in every human being whatever his claim to godliness,[17] then he will be able to secure his own personal code of behavior upon which he will operate for the rest of his days. This phase of a student's adjustment to life is a very personal one and does not routinely come under the scrutiny of his director, for a student lives this in his own privacy as he justly should. Let us then just be aware that it is going on and that the atmosphere which we create in our own living can aid and abet it.

A desire to represent the best in manhood and womanhood. This is perhaps the summation of all the factors we have named. In this period of transition a student may easily struggle against that which his seniors expect of him. Now he is preoccupied with trying to become a good therapist he is bombarded with tangible things, patients, techniques of treatment, records, supplies, and we must not so emphasize them that he fails to realize that becoming a good therapist is dependent upon first becoming a good person.

These are but a few of the common little things which the director of student affiliation and his junior staff members must hold in their consciousness if they are to give the student the best of any training experience. These are the little things which should be part of our own lives given through example that a student may develop his own philosophy of living—an acceptable law by which he will live each day of his life.

The student affiliation must also create an

atmosphere in which the student may evolve his own philosophy of work and of his profession. This again is not a tangible thing taught in lecture or through supervised patient treatment but it is a very real factor in graduating successful therapists. There are many elements in our working lives which go to make up our philosophy of work and of our profession. Most of these are common to all paramedical or ancillary services. Some are peculiar to occupational therapy alone and are so taught in our theory classes on ethics and etiquette. We feel, however, that there are certain basic concepts which the affiliation centers exemplify and would again enumerate a few in random order, for they too are the common little things which collectively make the big person if he will encompass them in his philosophy of work.

A dedication to the patient. The patient is the reason we exist. This maxim is so true and common that frequently it is forgotten. In our big clinics, particularly in our teaching clinics, the patient is frequently outnumbered twenty to one. He is surrounded by doctors, nurses, technicians, social workers and therapists and though he is always the focus of the group, he is not always given his rightful place. In our eagerness to teach we frequently categorize patients, lump them into groups and label with symptoms to tag for specific modalities. Here the student comes to prominence and the patient recedes. In our anxiety to give full treatment we surround the patient with a mass of records, tests, reports and schedules even to the point of eclipsing the human element. We tell ourselves too frequently that patient welfare has priority over all else and then we busy ourselves with the myriad of mechanical details related to his care. Mrs. Slagle was acutely aware of this and always directed her attention to the patient first. Even as she became more and more involved with the administrative phases of her department she kept her patient in proper perspective. This is a trait seen in all great physicians even as their work calls them into teaching and research fields. The ability to understand the patient and his human problems as well as his physical or mental handicap is always the clue to successful treatment.

An appreciation of where the textbook ends. In many fields we have accumulated a vast amount of knowledge and so have devised given treatment routines. In arts and crafts we have inherited through the ages acceptable techniques and methods. These have been formalized and expounded in textbooks. Usually it is true that a subject is not taught until texts are available and we are accustomed to this type of learning; it is comfortable and gives us security as we practice the knowledge so gained. Yet there comes the time when textbooks do not validate what is practiced, where techniques cannot be defined in print, and it is here that experience has the advantage over mere education. It has been said that the successful person is not always the one who envisions an idea, but rather the one who is able to sell that idea to others. Freedom from established fact or directive is gained through the years but respect for it should start in college. In helping her students understand the approach to patients Mrs. Slagle said, "There can be no set of rules or theories applied; simple tact, patience and common sense assist more than anything else."[18]

Here again is one of the reasons we support the apprentice type of learning experience. Let us encourage students to examine and observe the staff in its performance of duty, and foster a respect for things that are successful through experience, not alone through the textbook. A staff member should not be embarrassed if he cannot always produce a fact to support his premise or his act, if execution of that idea is successful in its end effect on the patient.

An avoidance of overconfidence in our methods. In her report as president in 1920, Mrs. Slagle said, "Much valuable time, no doubt, was lost in the beginning by an over-agitation of standards—nothing is more stultifying to progress than standardization in a comparatively new field of service—keep your program flexible—let us have ideals always, fine, strong and true to the proper development of the individual patient but let us not be overconfident of our methods yet. A great many of us have opinions concerning the proper way of administering occupational therapy, all, no doubt, perfectly good opinions, but the chief point for us to remember is that we are still representing only a small part of the treatment given . . ."[19] Continuous re-evaluation is a must.

A willingness to get in step with each institution. Preconceived ideas seldom helped anyone or any situation. Each clinic has its own problems, its own idiosyncrasies, its own weakness and strength. As we move from one to another we must be slow to criticize and quick to analyze. We must be willing to learn and to understand before we venture to change. Again Mrs. Slagle said that "we must carefully get in step and in line with the individual problems presented by each situation in which we serve, that the emotion toward our particular branch of work does not determine its force."[20]

A knowledge of how to support as well as to lead. Some say that leaders are born, others that they are developed, yet whatever you hold to be true you must grant that leaders follow before

they lead. A supporting role is inglorious yet can be the most satisfying of experiences. We cannot graduate a profession of leaders for immediately we have nothing to lead. We must instead give proper respect and recognition to those who follow. In a treatment situation the individual who contributes the most is the one who quietly goes his way treating his patients with sincerity and compassion without an overlay of wishing to do otherwise. The being of the clinic lies with the patient, the greatest contribution to its functioning lies immediately with those who work closest to the patient, for as they are successful the clinic justifies its very reason for existence. The routine treating therapist is the backbone of the whole program as is the duty nurse. Such a therapist contributes in other ways too—through his enthusiasm for his job, his optimism in difficult times, his flexibility in accepting assignments, his willingness to do the menial if needed, his "acknowledgment of the dignity of the cure of disease,"[21] his assumption that he must give beyond what he receives.

A recognition of the average, not just the superior. We cannot create a profession peopled only with the outstanding, the superior, the talented, but instead must remember that the majority of us will have average ability. We must respect this average and recognize it as our balance wheel for frequently it will prevent us from wandering at a tangent. We must develop a respect for the average and not give it a stigma by apparent oversight in our eagerness to acknowledge those who have unusual capabilities. We must appreciate it and encourage those who have this status, that they too may have the security of knowing that they contribute to our profession.

An acceptance of learning on the job. We cannot graduate experienced therapists. A new staff member cannot be proficient in all disability areas nor is he qualified to meet every situation presented in daily treatment. We are vocative in complaining that our young therapists do not know this or that fact or technique so vital to our own job or disability area. We fret because schools and training centers do not supply this needed skill. We should instead expect a new graduate to continue to learn—always, if he is wise. We must provide that opportunity and consider his first few years of employment as a continuation of professional training. We are each morally obligated to give this training whether or not our department has an active teaching program.

An awareness that facts need no embellishing. Again we quote Mrs. Slagle whose comments on record writing are pertinent. "From the beginning of hospital practice students are taught the value of accurate notes, that a fact needs no embellishing in the way of narrative."[22] This art is almost impossible to teach without benefit of practical experience and is one that we continue to learn for many years. We would interpret Mrs. Slagle's words another way, too, and apply them to the problem of argument versus the expression of opinion. A student must learn that a staff member must always supply facts to support his position or ideas but must never embellish them by narration which then turns the situation into an argument. This is true when any staff member is asked to inform his seniors of a given problem. If that staff member does not like the situation he is justified in reporting the fact of his dislike and may support that fact with comments to prove its logic. He may, however, never go beyond that point to argue or harangue for in so doing he only weakens his own position. Facts accurately presented stand alone and are well interpreted whether they apply to treatment progress or to a working situation.

An enthusiasm for small job benefits. As jobs become more plentiful in our profession and therapists continue to be short in supply, we frequently find ourselves trying to sell our vacancies. This is done through formal job analysis, or an advertisement or a letter. Let us never forget the value of the unsolicited selling which is done in the daily performance of the job. Our own enthusiasm for fringe benefits, our loyalty to the institution, or interest in our chosen field, these frequently form a more impressive bit of information than does the listing of hours, pay scale, increments and the like.

A recognition of the value of extra-professional interests. Not every therapist is a so-called career therapist. Some practice their profession with less enthusiasm than others. Those who devote added hours to their profession and exhibit an extensive interest in its organization become mechanical participants unless they have learned to add other outside interests. There are only so many hours per day and the therapist who works and then participates in extra-curricular professional activities must be particularly alert to other interests. Again we turn to Osler who said, "No man is really happy or safe without a hobby, and it makes precious little difference what the outside interest may be—botany, beetles or butterflies, roses, tulips or irises, mountaineering or antiquities—anything will do so long as he straddles a hobby and rides it hard."[23]

These are but a few of the common little things that we must cherish in our philosophy of

our profession. There are many more but these will serve to indicate why we feel that the concept of student affiliation must be in the broadest sense an apprenticeship. These things are learned by example, by experience, they become part of an individual as he sees what they have meant to others and so accepts them himself. This then is why we must today adopt a student for we must inculcate by example that through us a student will increase his own self-discipline and thus multiply his chances of enjoying his profession.

Many occupational therapists are concerned directly with the problems of student training and develop an amazing enthusiasm for this phase of our work which tends to overwhelm those therapists not so involved. This is understandable for it is a dynamic problem and a tremendous responsibility. Most of us are so absorbed with the vastness of it all that we tend to get it out of all proportion to the total practice of our profession. We would do well to think on the implications of this for a moment. There has developed, we fear, an aura which surrounds that occupational therapy department which trains students as compared to one enjoying a similar program but without students. As we educate more and more students and particularly as we see them go through the same clinical centers, we build up a whole wedge of our profession intimately familiar with a limited number of departments and their staffs. If a student has enjoyed his affiliation he carries with him a deep and genuine respect for those who taught him. As he attends his initial conferences he feels strange and young and unrecognized. It is natural then for him to welcome the familiarity of those with whom he trained.

We feel that the total membership of the American Occupational Therapy Association should carefully evaluate several current trends which we believe are directly related to this perhaps inordinate attention on the training departments. We have the greatest respect for our schools and their personnel and for the student affiliation directors and their staffs. We would, however, sound a word of caution that we of AOTA must not put undue emphasis on them in conducting our national affairs. The 1957 Yearbook lists 1257 agencies which have occupational therapy departments. Of these, 250 are recognized student affiliation centers used by the accredited schools. These departments employ 973 OTR's and the school staffs number approximately 86 OTR's, hence a total of 1,059 OTR's associated with students. The Yearbook lists 4,762 registered therapists of whom 3,138 are known to be working. Only one fifth of our departments and one third of the OTR's are participating in student education. A review of our Association shows that twelve out of thirteen standing committee chairmen, twenty-three of thirty-seven members of the House of Delegates, fourteen of the seventeen Board members and all of the officers are now, or were at the time of election or rise to national prominence, involved in student training.

We apparently choose our leaders from the schools and student affiliation groups and probably do so because they are familiar as well as capable people. Whether or not this is healthy is not for discussion here, but we would suggest that it should prompt those who are in training units to direct the attention of our students to the non-training departments. You of these departments can help. You can do so by your very active participation in local associations so that your names and abilities may become familiar to the students we bring to these meetings. Your expression of opinion on local and national matters is a vital factor in maintaining the proper balance. It is your key to gearing the policies of the Association to the particular needs of your departments. Your willingness to express yourselves clearly at local meetings will enable the student to understand the problems of the non-training departments in which they will more than likely find their initial employment.

A quick review of a recent issue of AJOT shows that seven out of ten of the papers written by OTR's were written by training personnel. So, too, were seven out of ten of the letters to the editor. Does this reflect the day-to-day practice of our profession? Where is the lone therapist who works without other registered occupational therapy staff members and without students? The common thought is that student affiliation staff members have more time, more freedom to write, more secretaries at their disposal. We suggest that they are simply prompted by their habit of teaching and by the very students who take up their time. A well-directed affiliation is never a labor-saving device for it takes hours of staff time and energy if it is properly guided. The non-training therapist has just as much time if he will but seek it. We urge that every practicing therapist consider it his duty to evaluate his work and to contribute some portion of it to professional literature. The expression of an idea or an opinion will do if there is neither time nor material for a full paper.

The non-training therapist can help offset the prominence of the affiliation center in many ways just as can the center itself. The combined efforts of both, and of the schools, must arouse a greater respect for the lone therapist and a greater opportunity for him to participate, perhaps

through attendance at student affiliation council meetings or at institutes. Whatever the method may be it must develop in an atmosphere which encourages the value of non-academic learning and this atmosphere can be created by all training and school personnel. Let us nor formalize everything to the point of overlooking the value of the individual. What we need most of all is a contributing membership to the American Occupational Therapy Association, not in the financial sense of a paid membership, but rather as an inherent part of each registered therapist's practice of his profession.

We have endeavored to present here our thoughts on student affiliation and its meaning to the individual student, to his director and to the members of this Association. In summary we would say that education belongs to the individual who receives it and, as we were once told, it is not to bank, to hoard, nor to squander, but is to ease the rigors of one's existence. If we would share our education we would do well to look to the little common things to lift one up and out and into a fuller life. As we earn our own education or guide others as they attain it, let us, however, always hold it secondary to a far greater thing—service—for service is the real meaning of our lives and of our careers. To it we must be dedicated or we do not live our profession. And with this thought we would give you one closing quotation from Mrs. Slagle, for we feel it is the true theme of all our lives, both personal and professional. "If we look to service, not to reward, we shall see in our own day, OUR work ministering to the highest needs of man."[24]

REFERENCES

1. Slagle, Eleanor Clarke. "Development of Occupations for the Insane," *Maryland Psychiatric Quarterly*, IV:1 (July), p. 19, 1914.
2. Slagle, Eleanor Clarke. Editorial, *Occupational Therapy and Rehabilitation*, 21:6 (December), 373, 1942.
3. Proceedings of the first annual meeting of the Nat. Soc. for the Promotion of OT. Spring Grove Hospital Press, Sheppard Hospital Press, 1918.
4. Proceedings of the second annual meeting of the Nat. Soc. for the Promotion of OT. Sheppard and Enoch Pratt Hospital Press, 1918.
5. *Ibid.*
6. *Ibid.*
7. Addams, Jane. Proceedings of the third annual meeting of the Nat. Soc. for the Promotion of OT. Sheppard and Enoch Pratt Hospital Press, p. 41, 1919.
8. Slagle, Eleanor Clarke. Proceedings of the fourth annual meeting of the Nat. Soc. for the Promotion of OT. Spring Grove State Hospital and Sheppard Pratt Hospital, p. 1, 1920.
9. Funk and Wagnall's. *Desk Standard Dictionary*. New York, 1946.
10. Slagle, Eleanor Clarke. "Development of Occupations for the Insane." *Maryland Psychiatric Quarterly*, IV):1 (July), p. 19, 1914.
11. "Essentials of an Acceptable School of Occupational Therapy." *The Yearbook*. New York: American Occupational Therapy Assoc., 1957.
12. Cushing, Harvey. *Life of Sir William Osler*, Vol. I, Ch. 22. Oxford Univ. Press, 1940.
13. Slagle, Eleanor Clarke. Letter to William Rush Dunton, Jr., M.D.
14. Osler, *op. cit.*, Vol. II, Ch. 26.
15. Etting, Gloria Braggiotti. "Go by Sea." *Town and Country*, August, p. 96, 1957.
16. Dupont (Irene Dupont's father, 1784). "The Duponts of Wilmington," *Life*, 42:8, p. 101.
17. Brunyate, William L. Letter to daughter, 1935.
18. Slagle, Eleanor Clarke. "Development of Occupations for the Insane." *Maryland Psychiatric Quarterly*, IV:1 (July), p. 19, 1914.
19. Slagle, Eleanor Clarke. Proceedings of the fourth annual meeting of the Nat. Soc. for the Promotion of OT. Spring Grove State Hospital and Sheppard Pratt Hospital, p. 1, 1920.
20. *Ibid.*
21. Pledge and creed for occupational therapists.
22. Slagle, Eleanor Clarke. "Training Aids for Mental Patients," *Archives of Occupational Therapy*, 1:1 (February), p. 17, 1922.
23. Osler, *op. cit.*, Ch. 29.
24. Slagle, Eleanor Clarke. Report of president, proceedings of the fourth annual meeting of the Nat. Soc. for the Promotion of OT. Spring Grove State Hospital and Sheppard Pratt Hospital, p. 1, 1920.

1958 ANNUAL CONFERENCE

American Occupational Therapy Association

●

OCTOBER 21-25

Hotel New Yorker

New York City

Keynote Address

A LOOK AT OCCUPATIONAL THERAPY

HENRIETTA W. McNARY, O.T.R.*

The keynote procedure of the 1958 conference is to take a *good look.* To look is a two-way process; you can be looked at and you can do the looking. Let us consider both.

How does occupational therapy look to others? This is judged by their comments. Complimentary comments can be filed away as self assurance. Such reassuring factors can be observed in the comments received daily from referring physicians throughout the country; in the increasing demands for occupational therapists, in spite of our pathetic effort to fill the many openings; and most particularly the improvement we see in the patients entrusted to our care. We know that in the American philosophy, the individual is important. We know occupational therapy is singularly important in helping the individual to regain human dignity and economic worth.

Non-complimentary comments should be studied in recognition of the fact that they are made in sincerity and represent the feelings of others. In that respect they are true. Whether such comments are deserved or not, they should be observed as warnings that occupational therapy in some instances has not proceeded with full effectiveness. This is what careful observation should tell us.

Such comments have given us some anxiety. This has been a healthy and stimulating factor. Carl Sandburg said that "A man who has no anxiety on his mind is dead from the neck up."[1] Anxiety is the basis for our look at ourselves; vision must start with insight.

In observing ourselves we have turned rationalization into rationale. As a national organization we have had committees at work for some time setting up the framework for expressing more clearly our objectives and functions as well as our philosophies and procedures. Others are in the hopper. These have helped us to think together and answer questions we have asked, first, related to educational programs and, more lately, related to clinical procedures. These data have served as a springboard for our further thought and enthusiasm. We have determined what we want. Self-seeking can be a virtue. This conference is the embodiment of your questions and your hunt for the answers.

You have asked for refinement of actual procedures in day-to-day performance. These are techniques. Occupational therapy will always need to keep a high flexibility in its techniques. May we never settle down to a routine, little way of procedure. Occupational therapy is not enough of an isolated science to select a formula, learn it by heart, and just apply it. As we talk techniques let us think of underlying principles and build procedure on scientific fact. The clues lie in the basic concepts of psychology, physiology and anatomy. We must turn to bodies of knowledge that have established principles known to be true. It is on these principles techniques can be built. May we talk to one another in such terms as we discuss how-to-do-it procedures.

Medicine is asking occupational therapy to be more aggressive in thought. It is asking us to grow with clinical practice. The doctor expects the occupational therapist not only to receive the prescription for what is written on it but for what is inferred in it. He must count on the depth and breadth of concept before he refers an individual case about which he writes on a little piece of paper. He could not possibly write all that he expects. There has to be a framework of mutual understanding on which to interpret the prescription. With such understanding you elaborate, improvise and expand the techniques through which you work with the patients.

You have asked for a better understanding of human relations, interpersonal relationships. You know there is a tremendous therapeutic force in recognizing the dynamics involved. You know that the relationship of the individual to the individual becomes very important as you work with patients as well as with personnel. Interpersonal relationships are strong in the group procedure. How can we best use this group factor? For many years it has been a therapeutic force in occupational therapy. As there is a shortage of therapists, we are increasingly obliged to handle patients in groups, sometimes larger than we would like. We can use the effectiveness of group dynamics to improve techniques.

You have asked for further information on evaluation. Evaluation starts with observation.

*Director, occupational therapy department, Milwaukee-Downer College, Milwaukee, Wisconsin.

One sees what he sees when he looks according to his ability to observe, according to his knowledge of what he looks for. Observations must be objective. One must not foresee what he thinks is there and be blinded to what is actually there. Clearly recognized facts recorded accurately and with meaning are prerequisite to evaluation. In reviewing some old records, I found them charming in their ambiguity. They had a nice flavor that showed feeling on the part of the occupational therapist for the patient and what he was trying to do. Much effort and support was written into the records. Accomplishment was vaguely recorded. It appeared that the patient found it difficult to keep up with the records written about him. We do not communicate well.

Close to evaluation is communication, oral or written. We need to refine our comments. Refining comment is not so much a matter of speech as it is a matter of knowing what to comment about. When one has something definite to say, one can say it definitely. When thoughts are fuzzy, comment will also be fuzzy. Communication is not simply a matter of words which are used in speech or writing. It is more a matter of how clearly we have thought out what we have to say, and the understanding of those to whom we wish to say it. Communication, like the look, is a two-way process. You say what you have to say to someone but he listens and responds according to his readiness to hear what you say. Therefore, his understanding will be dependent on his readiness. Part of the process of communication is to help that readiness-to-understand a m o n g our co-workers. We help their readiness as we help them to understand what is occupational therapy.

The speakers selected for this institute are excellently chosen to give some springboard for your thought. It is going to be up to you to translate their message. That is the responsibility of the discussion groups. The inherent value of discussion is to stimulate professional growth. Growth is slow. It comes passively only to children. Ours is a task of deliberate concentration.

As a profession we realize what we want, we will use what we have, we will determine what else we need and we will find a process through which to acquire it. This must be done with heart; it must be done with a love of doing. Robert Frost phrases it:

"Only when love and need is one
And work is play for mortal stakes
Is the deed ever really done
For heaven and the future's sakes."[2]

REFERENCES

1. Sandburg, Carl. *Biography of Lincoln.* New York: Harcourt, Brace and Co.
2. Frost, Robert. *Collection of Frost Poems.* New York: Holt and Co.

This issue of the *American Journal of Occupational Therapy* is published in two parts. Part I is the regular bimonthly issue and contains information relative to the 1958 annual conference to be held in New York City, October 17 to 24.

Part II of this issue contains the lectures from the conference held in Cleveland, Ohio, October 19 to 25, 1957. Since this was an institute-conference, with audience participation, there were few lectures. These therefore can be printed in full without abstracting the material as is usually done in our annual conference issue.

THE OCCUPATIONAL THERAPIST WORKS WITH GROUPS

JACK R. GIBB, Ph.D.

Your committee has planned an exciting and provocative day. Each of you will be, for most of the day, in a small work group where you will discuss the problems that confront an occupational therapist when he works in a group. A series of questions to guide your discussion is in front of you now. My role, as the committee sees it, is to talk for about an hour about ten principles of group behavior. I will try to relate each of these ten principles of behavior to the three problem areas: the work of the occupational therapist with patients in group situations; the work of the occupational therapist as a staff member; and the work of the occupational therapist with members of other professional groups. Your task is to think of the various principles that I am discussing in relation to each of the three problem areas that we are presenting. It is hoped that this thinking will enrich your discussion group experiences during the rest of the day. My role, in other words, is that of a catalytic agent to help you think about your problems.

I would like to start by inviting you to accompany a lady to one of America's great hospitals. This lady took a little boy with a heart problem to the hospital. The little boy, who was three years of age, was to be examined for a number of disabilities, among which was his heart problem. The things that happened at the hospital illustrate for us a number of current problems in providing patient care for people with various kinds of disabilities.

Many things happened that have implications for our learning. One of the dramatic events occurred during the terminal conference. A medical man talked with this mother about her child. The doctor talked with the mother in his best bedside manner, with all the sincerity that he could summon. He said that the operation was successful, that things were going to be fine for the little boy and then ended his talk with ". . . and, Mrs. X, there are a few little things that you will have to watch out for. Two things that I would suggest are that you don't let him run around too much outdoors in the first few months after the operation and second, have him drink plenty of water because the summer is coming on." All this was done, reportedly, with the most excellent human relations "manner." The only trouble with this set of admonitions was that at the end of the talk the mother was aware of two facts that apparently the doctor was unaware of. The patient would not drink any water, and hadn't drunk water. His lack of drinking water was one of his major problems as seen by the mother. The mother also knew that the child for three and a half years had been unable to walk. This was one of the main worries of the mother. This sour note in the interview produced in the mother a number of bitter feelings against hospitals and against hospital personnel. The doctor, apparently having only seen the child casually lying on a bed, and, apparently not having read the case history which was full of the above two facts, seemed to be treating the patient as a case and not as a person. Although the doctor's manner illustrated many of the most approved "human relations" principles he obviously was doing some things that created problems for the mother and for the reputation of the hospital among its patients.

Before I comment on this I want to talk about another illustration which I think provides an excellent example of the same major problem. This illustration concerns a graduate thesis done by a student of mine a few years ago in one of America's well-known hospitals. The study was of a group of patients with various disabilities. The student's problem was to find out the attitudes of these patients toward the people with whom they worked, with whom they lived, with whom they talked, and with whom they had contacts in their everyday activities in the hospital. The graduate student was interested in examining the interpersonal system of the hospital community and the role of the professional person in providing an atmosphere for the patient that would be recuperative and therapeutic.

The researcher found out many interesting things, only one of which I wish to discuss for my illustration. The following question was asked of a number of patients used in the study: "To whom during your period of hospitalization would you most like to go to find help in discussing a personal problem?" The researcher was trying to find what groups of people the patients saw as being understanding and sympathetic. The researcher tabulated the people who were listed by the patients as being the persons to whom they would go in the solution of these problems. Only one patient mentioned the doctor. The others mentioned were: the janitor, the elevator boy, the mother, one of the fellows on the ward, the cleaning woman, etc., etc. In other words not a single mention in

*Fels Group Dynamic Center, University of Delaware, Newark, Delaware.

the seventy-five protocols of a nurse or of one of the professional people working with patients, although these people were presumably professionally trained for the very relationships in question. These are very disturbing data.

In both illustrations above we see examples of how hospital personnel build or fail to build the kind of interpersonal relationships that produce growth, therapy, and warmth of understanding. When we look at illustrations like these we find that the perceptions of people are the single most important dimension of behavior from the standpoint of one who is attempting to influence or change behavior. Perceptions are significant. They influence attitudes. They influence emotions. They influence relationships. Each of us is caught up in the impersonality of modern life. We perceive persons not as persons but as things and events. If we are to help others to work more effectively with people, with people in groups, we must help them to perceive people as persons, as living, dynamic, warm, personal experiences.

Let me give another illustration of the importance of perceptions in human lives. We performed an experiment in which we took two groups of thirty-two people each. One group of thirty-two people, group A, was given sixteen weeks of intensive training in "participative action," a kind of human relations training developed by a group of graduate students working with us. Another group, group B, of thirty-two people who served as a control were matched with thirty-two people in group A, but were given no such training. Before and after the sixteen-week period, each of the sixty-four people was given a number of measurements relating to their effectiveness in interpersonal relationships. We found, disturbingly, that the control group improved just as much as the training group in the ability to act in such a way as to be perceived as different from the way they were originally seen. The people in both the experimental group and the control group improved in "role-flexibility" as measured by the ability of people to induce changes in the way they are perceived.

Each person who was being measured in the experiment was placed in a small discussion group in front of a group of raters who did not know the people being measured. The raters judged each person on several dimensions. For instance, each person was rated on the dimension "warmth-coldness." Those people originally seen as cold were asked in the test to act in such a way as to be seen as warm. Members of the control group improved on the second test of this ability. They seemed to be saying "Oh, I see what you want me to do. You want me to proceed as a warm person. All right, I can be perceived as a warm person." These people were seen as warm people, but were seen as insincere warm people, in other words, people playing a professional role. They were seen as cold people acting like warm people. What training did, as indicated by the measurements of the experimental group, was to help people to feel warmth toward other people and hence after training when asked to act in such a manner as to be seen as warm persons, were able to be seen as persons sincerely feeling warmth. The training was very effective. The trained people, possibly because they felt that way, were perceived as sincere on the rating forms. If we are seeking to improve human relations training, we need to devise a method of training that will help people to behave in sincere ways towards others, not in the "professional" manner. In these days in the complex worlds of hospitals and other large organizations, where all of us are trying to build new ways of relating to others, it is necessary that we find ways of building satifying, warm relationships. This is necessary not only in the therapeutic relationship with patients, but in the quasi-therapeutic staff relationships—with the people with whom we work. Our culture is an emotionally deprived one. We live on emotion deprivation diets. This is one of the reasons why some of my colleagues are able to sit one hour doing an interview in an office and may "uh huh" with varying inflections and make patients feel good. I suspect that the reason the patient feels good is that there are so darned few places in the world where he can talk to or with someone who isn't bawling him out, censoring him, or criticizing him for his attitudes and his feelings. It seems that our need for a warm relationship is such that the psychologists or psychiatrists can play the prostitute role with a person and still be fairly effective in helping the person to build new relationships with others.

Perhaps I'm suggesting that we need to build in our relationships with others the kind of warmth and support and acceptance in our patient groups, our staff groups, and our interprofessional groups that are potentially therapeutic in nature. This will be difficult because we have all kinds of insecurities and feelings and inabilities—because we are people. If we weren't people we could probably do much better at this.

How do we build these kinds of relationships with others in patient groups, staff groups, and inter-professional groups? I would like to talk about ten general principles. In each case I will try to give some illustrations which indicate

how each of the principles can be applied in each of the above three areas.

1. *The goal studying principle.* This principle itself is fairly simple. The applications of it are rather difficult. The principle goes something like this: To the degree that we in groups set our own goals we become more involved and we become better, more productive group members. To the degree that hospital wards, student governments, nursing staffs, curative workshops, and other functioning groups set their own goals they become more productive, more effective, more involved in the work of the group. The work as a result becomes more efficient, and of higher quality. How do we do this? I suspect that one of the reasons that the old cartoon making fun of progressive education was funny —you remember the cartoon: "Teacher, do we have to do what we want to again today?"— was not that students don't want to set their own goals, but rather that it is so very difficult for thirty kids to decide what they want to do that they would rather have the teacher do it. Then they can criticize the teacher when whatever they are doing doesn't go just right. People like to set their own goals. When they run into conflict with others who have slightly different goals, or who are seen as having slightly different goals, problems arise. Students—and people—learn to turn to an authority to set goals for them. Thus dependency gets reinforced.

It's not easy for therapy groups to set their own goals. It's not easy for staffs. It's not easy for patients. I suspect that we have so many different motivations for going places and doing things and being in groups, so many goals at so many levels that it's difficult for us to arrive at satisfying common goals that we can work on now. I suspect that we'll have some of these problems in the groups today—the groups of ten. One person might feel, "I'd really rather spend my time with my patient groups because that's mainly my concern." Someone else might say, "Well, I'm not at the moment working with patient groups. My problem is that of an administrator primarily and I'd rather spend our discussion time talking about our problems as staff groups." Then what will we do, the ten of us? We'll have to work out a common interest that we can work on for four or five hours together—or several common interests. We will have to arrive at some compromise, or better, arrive at a new synthesis of a new goal that will be better than any of the individual goals that we came with—as a result of our working together—that will make our working together satisfying for all ten of us.

These goals that we have are multiple. They exist at many levels of awareness. Some are unconscious. Some are conscious. There is no need to remind people in an audience like this that these things are true. These many-leveled motivations sustain us in all the kinds of things that we do. I suspect, for instance, that the reasons for coming to this group are multiple. Some of them had to do with the hope that this would be an educational, exciting and informative experience. Some of them would have to do with the hope that it would be kind of fun to go to Cleveland for a week. Others of us may have wanted to get away from our jobs. Some of us may have wanted to get away from our wives or our husbands. Some of us may have wanted to do some shopping. Some of us may have just wanted to get away and see some of our friends. Some of us may have wanted to make a new job contact. Out of this tremendous welter of motivations we will have to create for a time a common goal that will give us a satisfying experience for four or five hours in a group of ten people. And we'll have all the blocks to doing this that people have as they work together. These motivations, whether we like it or not, will sort of interfere and determine how we react to the problems that we have in the groups, to the leadership that we have in the groups and to the individuals that compose them. One of the leaders we have in the group might remind us of Aunt Betsy or of the boss back home, and we'll have problems in working with this. Shaw tells a little story that I can't resist telling now, which illustrates the dynamic and pre-existent nature of underlying motivations that affect our behavior in peculiar ways. This is the story—and modifying it a bit—of the lady who had two little girls. One night a man was coming to dinner who had a huge nose—the kind of nose that everyone saw first and thought of first when they thought of Mr. Brown. This nose was the most dramatic thing about Mr. Brown, and the little girls' mother was worried about what the girls might say when they saw him. They were like other little girls and occasionally they might say "Oh mommy, look at that man's nose;" This just panicked her all day until she devised a system whereby she would let them come downstairs and introduce themselves to Mr. Brown and then she could send them quickly upstairs. The whole thing would then be over with and the girls wouldn't have had a chance to say anything other than the controlled things that the mother had specified that they could say. Came the evening —came Mr. Brown. The girls came daintily downstairs and said, "How do you do, Mr. Brown." "Well, hello, Debbie and Mary." And

then they were whisked upstairs and the mother after a tense day of anxiety about the girls' behavior sort of relaxed and said, "I'm glad that's all over. I don't have to worry about that anymore." She sat down at the table a bit later and started to give Mr. Brown some coffee, saying, "Mr. Brown, would you like one or two lumps of sugar in your no—in your coffee?" We can just picture this continuing fight within the system of the mother, this anxiety, this worry, this accumulation, this motivation that persists through most of the day. Comes the end of the episode that produces the anxiety. The resulting reduction of the inhibitions, the reduction of the censoring or whatever you want to call it, and then in this in-a-relaxed-mood pops up the submerged, repressed response that has been inhibited at a continuing energy cost to the mother. All this is represented in speech, in slips of the tongue, in dreams, or whatever subliminal life we might glimpse at times. These motivations at all levels—individual, group and task—are continuing, complex, dynamic and interactive. Out of this many-leveled stuff emerges, in an interactive group, a common sustaining group goal. To the degree that we work through the many kinds of goals of as many of the members of the group as we can we get satisfying, productive and creative group work. We see exciting results when family groups work through to a common goal at a deep level. Patients who produce a group-decided student-body government, staffs that have conflicted through to a common understanding of a common task, and mixed professional groups that arrive at a program that meets the greatest number of needs of the greatest number of people, all illustrate this goal-setting principle.

2. *The decision-making principle.* Here again the principle is easy to understand and the application to many practical situations is difficult. The more the total group becomes involved in making decisions the more effective will the group be, and the higher the quality of the decision. Groups will become more effective as they become more involved in making their own decisions. Decision-making is difficult and time-consuming. An apparently easy way out for the administrator is to make the important decisions and to leave the simple, easy and unimportant decisions for the group to make. The administrator then wonders why the group gets an increasingly futile feeling about decision-making. There have been some fairly good recent studies that indicate that all group action may be quasi-therapeutic. For instance, some of the benefits of collective staff action will be to reduce the anxieties and the tensions of the staff, gird them for new interpersonal battles, support them, give them a kind of collective therapy. All effective group action can be this way. Possibly because of the ambivalence that all of us have toward authority—because of the defensive resentment, conscious or unconscious, that we feel toward policemen and teachers and leaders and authorities in general—all of us find group decision-making a difficult matter. In even the most minute decisions in a group, whether made by an administrator or made by the group, we find the material for working through our dependency relations with others. We feel some need to be involved in our own destinies—to make our own decisions— even if it's only making an agenda, deciding which pencil we want to have in our office, deciding on the kind of rug we wish for our conference room, or whatever. Administrators are continually shocked by the many revelations of the needs of functioning groups to make decisions. Practical life forces administrators to delegate many important decision-making functions. Even the most careful administrator or committee will brush against authority needs when making even minute decisions. Accumulative tension and resentment, often largely unconscious, builds up to plague the administrator during apparently unrelated activities with his staff. Once in a while the administrator comes to feel that the group doesn't want to make its own decisions. You may hear a rationalizing administrator say, "They simply don't want to make any decisions. You give them a decision to make and they waste time, they fritter it away. They say, 'You do it.' Perhaps the best illustration of this that I can think of occurred in a staff of which I was a member. The staff was composed of about twelve psychologists, some of whom were clinical psychologists and some of whom were social psychologists. This group made a professional living at talking about the behavior of people working together. There were even two professional group psychologists on the staff. Then came the day when the president of the university decided, out of the largeness of his paternalism, to give a little $500 bonus. The decision was left up to the department as to how this bonus raise was to be distributed among the twelve staff members. I suspect you know enough about university salaries to know that this $500 was fairly important to these people, but not nearly as important as who was going to get it. So the group went through all kinds of consternation to make this decision. They finally decided to rate each other anonymously as to each person's deservingness in getting a bonus. Each person was to list the top three people that he

thought should get some of the $500. The chairman was to take these ratings into his office, tabulate them, and decide the top three people. After doing this the people began to get panicky and during the week something happened in the staff. The next time we had a staff meeting, about a week later, the staff brought up the problem, and, before the chairman could announce the results, said in effect: "We want to talk about this again. This wasn't a very good decision. We don't know whether we as a group could actually make this decision. Do we know people well enough?" You would hardly believe this but we then met for a series of evenings to work through the problem. What were we working on? The $500? Probably not. We were working on some important fundamental relationships among people. What we finally decided—and to you sophisticates this will say more than anything I can say about the nature of this group and its relationships—was to say in effect: "Mr. Chairman, would you make this decision for us? Then we know it will be all right—Daddy. We are afraid that we don't know each other well enough to make such a decision, and we are rather afraid of the whole problem of making these big decisions anyway. And again, if you make the decision for us then we can complain about it if we don't like it. If we make it ourselves then the blame will fall on us." Many groups are in this state, this state of crippling dependency, the inability to move. Why? Because most of the groups we live in have been brought up in this way. We don't know how to make decisions as groups. How to make decisions in groups is an important problem that is now being studied by social scientists. We know that making decisions as a group is effective. We know it is therapeutic. We know that at one level of awareness groups want to make decicisions. Administrators should not kid themselves. Therapists should not kid themselves. Occupational therapists should not kid themselves. This group of psychologists were kidding themselves. Probably one the nicest things this chairman could have done for the group would have been to have forced the group to make its own decisions, in its growing up process. This group, incidentally, began to show many other signs of its collective neuroses. The next year the group chose as its chairman a pleasant, harmless man who was one of the least able of its members. Apparently the group felt safe under the aegis of a kindly, fatherly chairman, whom it could control.

When faced with important decisions, administrators or therapists have at least three alternatives in dealing with the decisions. They may make the decision and then in some subtle way try to persuade the group of the validity of the decision. Or they may force the group to make its own decision about the matter. Most of us as staff administrators, as group members, and as therapists are pretty well aware that the first method is ineffective. People cannot be ordered to do things in an arbitrary fashion.

I would like to say a few things about the second method of decision-making in groups, the method of deciding and persuading. The decision is made by some person and then people must be convinced, persuaded, given reasons, given communication down channels. A common variety of this method is for the chairman to suggest that the group meet and discuss the problem, the chairman hoping that the group will come out with the same decision that he has and that some magic process of "involvement" will occur. This second method does not work either. Persuasion is a growing disease of our culture. We've about had it as far as persuasion methods are concerned. We don't buy any more. We ask ourselves why the nurse wants us to behave this way. •What does the occupational therapist have up her sleeve? Why does the director want us to make our own decision? One of the common garden varieties of reaction toward group dynamics is to have people say: "They are trying to get us to make our own decision—what are they getting out of this? What are they trying to do to us? Why are they trying to get us to make our own decisions?" We listen to TV and we hear Mickey Mantle reading a script in the background, "I use Atlantic gasoline because it is so good for my car." Few people entertain for a moment the belief that Mickey actually uses Atlantic gasoline, or even care whether he does. The audience member is speculating about the amount of money Mickey made for making the statement. We develop a collective cynicism about the motivations of people who try to persuade us. Propaganda and education and persuasion have become so ineffective as a method that people react adversely to being persuaded and become defensive and resistant. We ask, "Why do they have to persuade us of this?"

I'm reminded of the first two weeks in almost any elementary psychology course. Psychology happens to be my professional field and I have strong feelings about it. Each of you who has taken elementary psychology or who has taught it will recall, I think, one of the major topics in the course—the scientific method. In order to understand the reason for having this topic in the course you must realize the position

of psychology in the hierarchy of the sciences. It isn't accidental that psychology is in the basement of the big building or in the main part of the temporary building that has been on the campus for twenty years. During the major part of the first two weeks the professor is likely to say something like "Psychology is *too* a science. The reasons that I know it is a science are these twenty-three reasons. Write them down and memorize them for a test. It is *too* a science!" I wonder why we don't hear things like this in a physics course? Nobody bothers to argue that physics is *too* science or that Harvard is *too* a good school. When we are defensive we persuade. Our defenses are aroused by persuasion. Defense leads to defense.

Perhaps the only effective way, the third way, of getting good decisions made is to work with one's group to the point where the group can comfortably accept the responsibility for making its own decisions and has learned the skills of working together to make its decisions. The group must face up to the problem of making its own decisions together. This was true of the war-time experiments on eating soy beans. This was true in a number of interesting experiments in the laboratory which demonstrate very clearly that people's motives and attitudes are changed when they have an opportunity to talk through a problem and work it out. This is true when they feel that it is a sincere, real opportunity, not an opportunity that someone gives them because it might be therapeutic or involving. We can often see the terrible necessity of having patients, staff members and people make their own decisions.

3. *The continuing evaluation principle.* Groups are more effective when there is continuing evaluation by the group of its progress toward its goals. When there is a good feedback system within the group, members are more satisfied and the product of the group tends to be of a higher quality. The process of evaluation can be broken down into two sub-processes —data gathering and feedback. The important data that must be gathered on the group have to do with the group members' perceptions and the group members' feelings. Feeling and perceptions are "facts." In order for a group to move effectively in choosing goals and in making decisions the group members must have reliable and valid data on perceptions and feelings. One informative aspect of the study mentioned above in which the graduate student gathered data on the feelings and perceptions of patients on the wards was the shocked feelings of the nurses and occupational therapists when they saw the results. This has something to do with the effectiveness of the total feedback system. We are all familiar with ineffective feedback. Who is the last to know? The supervisor, the chairman, the boss, the top dog—these are the people who are "protected from" the perceptions and feelings of the people who work under them. Our job as therapists and staff members is to help create supportive climates in the groups with which we work—where people know how they feel, know how each feels about each other, know how well they are doing on the tasks that confront them—in other words a climate which permits functional data collection and functional feedback. The knowledge that somebody feels a particular way about you is helpful to you in your adjustment in the group. It is often better to know others' feelings, even when the feelings are slightly negative, because often our fears about others' feelings are worse than the feelings themselves. By and large people feel toward others quite positively. This is particularly true with a high amount of interaction. The more people interact with each other, *in a supportive climate,* the more people will learn to have empathy toward each other and will understand each other. When feedback is inadequate or distorted our anxieties about people's perceptions become exaggerated. These anxieties then interfere with the task of the group and with the therapeutic results of group action.

We are all familiar with poor feedback systems. I will give an example of one or two particularly poor feedback systems. One example is taken from a study of a small Michigan community which had always voted Republican, not unlike other communities in Michigan. In all major national, state and local elections this town had voted Republican. A research team went into the town, took a sampling of three hundred people of voting age from the town of 8,000 to find out something about these three hundred people. In other words this investigation was interested in the feedback mechanisms of the community. Among other things they asked of three hundred individuals: "If you had to vote in a national election, which party would you vote for if you didn't know the people or the issues?" Approximately one hundred eighty people said they would vote for the Democratic party candidate and approximately one hundred twenty said they would vote for the Republican candidate. This was interesting to the investigators inasmuch as the town had always voted Republican. Then they asked: "How many of you registered in the last election?" Ninety Republicans and eighty-one Democrats had registered.

They were asked: "How many of you voted in the last election?" Of the group eighty-seven Republicans had voted and sixty-five Democrats. That checked almost exactly with the ratio of voting in the previous election. This indicated, incidentally, that the sampling methods were pretty good. The interesting thing from the point of view of our discussion this morning in terms of feedback mechanisms is that the investigators interviewed the people who did not vote but who had preferences. They were asked: "Why didn't you vote? Give us some of your reasons." The major reason for not voting given among the Democratic group went something like this: "There is no point in voting in this town. It's a Republican town!" Now I suspect that this condition of low and invalid feedback, where people don't know how other people feel about certain issues, is not confined to this little Michigan town. Did you ever see hospital settings where staff members didn't know how other staff members felt about matters? Or schoolrooms or hospital wards? Or committees?

Another study performed by a student was an investigation of teachers' and students' perceptions of each other and of their goals. The teachers ranked ten goals as they thought the goals of the classroom should be. They also ranked the ten goals as they thought their students might rank them. The students in the classes ranked the goals as they thought they should be ranked, and also as they predicted the teachers would rank them. Very fascinating data. Among other interesting findings, one point that stood out was that the ratings by both the teachers and the students of their own goals were much more similar than the ratings that they attributed to the other groups. Which group would you think did the poorest job in accurately predicting the ratings of the other? The teachers. The teachers—and these were university professors—were living in their usual world of unreality, with only the vaguest idea as to how the students felt, what the students' goals were, and how students perceived the world. Teachers seldom bother to ask the student what he wants in the classroom. We teachers often prefer to assume that our perceptions are valid rather than to gather data upon such matters. Think back over how many classrooms there have been in your experience where the teachers have made genuine and prolonged attempts to find out your perceptions and feelings about what mattered in the schoolroom.

I have had experience over the past few years working in hospital training programs with administrators, auxiliary women, patients, doctors and nurses. During the various sessions for one reason or another role playing was done to illuminate problems that the group saw as central to their human relations. Almost invariably their central problems involved other hospital personnel, patients, or parents of patients. One obvious generalization from these experiences that is inescapable is that a central problem for hospital personnel is the collective misperceptions that each group has of the other. When parents role-play a hospital scene, they see as the trouble spots the receptionist, the nurse and the doctor. When nurses role-play a hospital scene, they see as their central problems the patient, the parents of the patient, the doctor and the administrators of auxiliary services. When women members of hospital auxiliaries role-play their problems, they see administrators, doctors and nurses as blocks to the accomplishment of their aims. Similarly, when hospital administrators role-play, they see their problems as doctors, auxiliary women, nurses and patients. The hostilities of hospital administrators toward staff professionals remind me of the only comparably intense set of feelings that I can think of, hostility of university administrators toward academic personnel. Perhaps a comparable set of intense reciprocal misperceptions exist in the feelings of the borderline and auxiliary professions toward the central medical profession in the hospital setting. The feelings of nurses and receptionists toward the patients coming in gives one the impression that they feel that hospitals would be "wonderful places if it weren't for the patients," which is like the feeling that university professors get that "colleges would be wonderful places if it weren't for the students."

These states of misperception, due to inadequate feedback, exist in most institutions. When they produce feelings in the public such as the feelings produced in the illustration that I used earlier in the talk, they create profound and permanent feelings about institutions. The problem for us as administrators, therapists or committee members is to set up our groups in such a way as to maximize feedback about perceptions and feelings in the kind of climate where people are able to look at and learn from such feedback.

4. *The atmosphere principle.* Certain climates facilitate growth, learning, productivity, and enjoyment of group action. Certain other climates tend to reduce growth, learning, therapy and productivity. Climate is a difficult thing to measure. We can sense the climate in most groups we are in or at least we think we can sense the climate. For instance, I sense that the climate in this audience is a very accepting one. People respond easily. Apparently the activities of last night and yesterday and the activities in this

organization in previous meetings or whatever you have eaten for breakfast have produced a good feeling in the group. The validity of the perception of climate is always in question of course. My perception of this climate is probably colored by my own good feeling at the moment or by my hope that you have a receptive feeling. In terms of checking this validity, of getting feedback, an interesting question is: "How would we test the climate of this group? How many of you feel good?" This approach is probably not a very valid method. At least when asked publicly your response would probably be colored by your need to exhibit polite behavior to an invited speaker. Fortunately, the world we live in is a world that is protected by our projective perceptions. We create a world that we would like to live in. If we like this conference we are likely to say: "People surely do like this conference, don't they?" If we don't like it, we might say to people back home: "Golly, people surely didn't like the conference in Cleveland!" What are these people telling about, the conference climate or themselves?

The climate or general feeling in the staff meeting, or the therapy group, or the hospital ward is far more important than the specified rules that can be set up for dealing with people. I remember an example a few years ago when we were living in a housing project where, because houses were newly built and no trees were as yet planted, we could easily hear the child-rearing practices of people who lived nine or ten doors in any direction. In fact you couldn't avoid hearing them! I remember that across the street lived a little girl about two and one-half years of age. She used to run into the street and her mother became extremely irritated at this behavior. Especially toward the end of the day you could predict that sometime the mother would come running out of the house, see the little girl, and as the little girl would run screaming toward the house the mother would whack her two or three times across the side of the head, fairly hard—at least hard enough for the mother to feel better by the time she got into the house. At first I was about to call the Humane Society. I felt pretty bad about the situation until I began to observe the household and other relationships. I found that the child was adjusting pretty well and that the climate in the home wasn't as bad as the climate in many of the other homes in our neighborhood where people didn't spank children. I am purposely using a very extreme illustration and I am certainly not saying that I am in favor of hitting children, but I am saying that whether or not you slap a child is not nearly so important as the general atmosphere in the home and the kind of acceptance and love you give him. A parent might blow off steam once in a while and this may certainly be better for the parent —and for the child—than for the atmosphere to be psychologically punishing, for instance. One cannot simply memorize rules about behavior in complex social groups. One can't say that parents should or should not spank children, but one can talk about the kinds of climate in homes where mothers build relationships among family members. The home above was perhaps not the best in the neighborhood but it wasn't the poorest. The general climate that we create of acceptance, of warmth, of emotional togetherness, of accepting differences, of permitting people to live differently—this kind of climate is the important matter in therapy groups or in staff committees.

5. *The feeling-orientation principle.* Groups are more effective, therapeutic and productive when they are oriented toward the feelings of the members of the group. Here the group leader has an obligation. Essentially our culture is a feeling deprivation culture. We live pretty much at a cognitive level. We work pretty much on tasks. My wife had a bridge group that met the other night from nine o'clock in the evening until a quarter of two the next morning. When she came to bed, I asked her: "Gee! how many rubbers did you play? Nineteen?" She said, "Oh, we played four hands." What does the group meet for? To play bridge? I don't think so. I do think it is necessary for them, in our culture, to pretend to themselves that they are meeting to play bridge in order for them to decide to meet at all. Having a task to do, even a game to play, gives the sanction to the group to meet, to gossip, to talk about themselves and other people, to meet the needs that people have to interact. We are not nearly to the point in our culture where we can accept the notion that: "Let's have a staff meeeting for an hour or so with a group of us so that we can learn to enjoy each other better." Most of us feel that we must do our socializing and interacting at off hours because social interaction is not productive work. Our task oriented culture is such that we must excuse even our leisure time by giving it the formal sanction of a recreational contest.

It is necessary for us in a professional meeting like this to have papers for the usual work hours. We must give papers and have talks in order to rationalize our needs to come together once in a while and become better acquainted with people who have common interests and backgrounds. I am sure that among professional groups like this one the effects of feeling-orientation in staff groups are not so well known.

One of the latest studies of industry indicated that the most productive supervisors and middle-management executives were those who were feeling-oriented, who for instance "turned the waste basket over" by the worker's workbench and asked him: "How is Mary doing in school this week?" rather than concentrating too much upon the production figures, absentee rates or other measures of task performance. Apparently even in work groups and professional meetings it is important to the productivity of these groups for people to react to each other as people, and for leaders to help the group become aware of member feelings and perceptions. Staff groups in hospitals and in curative workshops are not too different from therapy groups.

6. *Expectation-meshing principle.* In order to develop effective staff meetings and effective work groups and effective therapy groups it is necessary that the expectations of group members be somehow meshed together in the interaction. When expectations are too much violated, people spend too much energy in orientation and possible fighting of the new norms. Our work groups today, for instance, will be greatly affected by our individual attitudes toward working in such small groups. Each of us over a period of time has acquired from our relations with such work groups expectations as to how they should be handled and what we should do in them. All of the work group leaders, if I can interpret the feelings of the meeting this morning and of work group leaders, are now somewhat anxious about the expectations you have for these work groups. They were kidding about this a great deal and I suspect there is always some reality in joking. Their concern was about our expectations of them as leaders and how they could meet the collective expectations that we had. Our expectations color our perceptions of the leader and of the work group. We tend to project our expectations of what work groups should be into the instructions that we are given, even distorting the instructions so that it becomes extremely difficult for leaders to meet these projected expectations. My brother Bill tells a story, aprocryphal, I think, which illustrates this point. He tells the story of his first date with Bonnie, who later became his wife. After their first date Bonnie's mother began to conduct the usual probe interview that mothers conduct of daughters after first dates. Bonnie's mother asked Bonnie, "Well, how did you like your date?" "Oh, he was a nice fellow." "What did you do?" "We went to a movie, had milk shakes." "What did you talk about?" "Oh we talked about this and that." "Was he a nice fellow? Would you go out with him again?" "Oh sure, I liked him a lot and I would go out with him again." After quite a bit of this probing Bonnie finally volunteered: "But you know, mother, he knows the dirtiest, filthiest songs of anybody I have ever been out with!" Her mother sort of reared back at this because, according to Bill, she didn't have this perception of Bill. "Gosh! do you mean he actually sings these songs when you are out on your first date?" "No, but he whistled them all evening." Bonnie tells the story somewhat differently! In any event I think the story illustrates rather well the contribution to our groups that we bring with our preperceptions, our preconditionings, our expectation and attitudes toward authority, our attitudes toward people. It points to the necessity for those of us who are working with people in groups of any kind to learn what these expectations are, to learn where the group is, to learn what we are ready for. Leaders and therapists must work from the point where the group is. This fits in with the feedback principle, of course, and the feeling principle. They are all interrelated. The reason that we spent more time on the earlier principles is that these last ones are in some ways derivatives of the earlier principles.

7. *The boundary principle.* The idea here is that group action is more effective if boundaries are clear. Boundary clarity and boundary permeability are important group dimensions. Management has recognized this principle for a long time by establishing lines of responsibility, indications of what members have to do. Actually I believe we are finding with work in organizations that matters aren't as simple as seems to be indicated by the usual principle of responsibility. We cannot simply plan, organize our work, delegate it, then supervise—to quote a little ditty that I read in an administration book the other day. In life, administration just isn't that simple. It is extremely difficult to pinpoint responsibility and then carry it out. Responsibility is often diffused. Roles are unclear. None of us are exactly clear what the relation between OT and PT is. We are not exactly clear what the relationship of our profession to the nurse on the ward is, or what our obligations to the parents are. The boundaries among the professional groups dealing with therapy are very unclear. One hears various professionals talk about such matters as "Certainly that group can't do that kind of work with patients, because it would be therapy!" I guess this means that you can work with people in groups as long as you don't help them too much. I am only partly kidding because I suspect that what happens in groups is that all groups are quasi-therapeutic for the members. The old boundaries between therapy and non-therapy are not as easy

to draw as we once thought. The more we understand the therapeutic process the more we find that it is similar to the processes of growth and learning and development and maturation. Boundaries can become clear only in interaction in supportive climates. Boundaries are not made clear by protocol. Continual, supportive interaction tends to establish working boundaries which are functional to people. These boundaries may transcend the usual definitions and the usual professional, hierarchical relationships. It is important that we establish and clarify our attitudes and boundaries so that we can reduce the ambiguity of the situation for new persons in the group, for new persons on the staff, and for new patients on the ward. People must know the boundaries and the limits. This reminds me of children—great boundary testers—who seem to be thinking to themselves: "How far can I go? How tired is mother?" Adults seem to be asking themselves: "How authoritarian is the supervisor? How late can I be? What rules can I safely break and what ones shouldn't I break?"

8. *The distributive leadership principle.* Other things being equal, groups are more effective when leadership is distributive. We can divide the actions of any group into a number of roles. For instance, in order for any group to work well there have to be certain kinds of roles taken at appropriate times. Action must be initiated. Locomotion must be regulated. The group must be informed. Actions must be supported. Decisions must be evaluated. The more these functions are centralized in the chairman or the staff leader or the therapist, the less the learning and growth and effectiveness of the group. In general, other things being equal, the more these functions are distributed among the various members of the group in interaction, the more effective is the group. The shared feeling of responsibility results from distributed action. The chronic state of affairs in most groups in our culture is demonstrated by one of my favorite cartoons. The cartoon shows two little boys playing on a bed upstairs. One little boy looks up at the clock and says: "Gee whiz, look at the time! If Daddy doesn't hurry and get up here pretty soon and make us go to school, we are going to be late!" And this feeling—if someone doesn't do something, if the therapist doesn't help out in this group, if the administrator does not make this decision soon, if the teacher does not tell us what to learn, if somebody doesn't plan this party for us—this feeling is a crippling one for healthy groups. Groups can only be permanently healthy when members feel a collective sense of responsibility for the actions of the group.

9. *The provision-try principle.* Groups are more effective if they develop a norm of experimenting together. Effective groups have the norm that their actions are provisional tries, provisional attempts to find a way that works, to find a rule that will be effective for the ward, to find a method of setting up a ward organization among patients, to find a way of the staff working together, to find how far we as a therapy group can explore feelings together. If we can build into our groups the feeling that our decisions are to be tested, that they can be modified, that they are flexible, that the by-laws and agenda are not always to be with us, then we can become more effective as groups. The provisional-try norm is an essential one for groups living in a democratic culture.

10. *The training principle.* All that I want to say is simply that groups can be more effective if their norm is one which sanctions their learning together. In effective groups people should be continually upgrading their interpersonal, decision-making, and group problem-solving skills. People are learning to take shared problem-solving attitudes toward themselves and their common problems. Effective group action skills can be learned. I think this is similar to what I am saying when I say that all group action can be therapeutic. When we develop our staff potentialities in our face-to-face interactions with other people on our staffs and in our groups; when we can build into these relationships the kinds of mechanisms that permit each of us to learn more and more and grow more and more in our skills of working with other people; when we build hospital teams and therapy groups that permit continual group and individual growth—then we are participating together in the effort to build a more productive and satisfying democratic society.

THE THERAPEUTIC USE OF SELF

JEROME D. FRANK, M.D.

First of all, I should like to express my appreciation for this opportunity to address you today. As a psychiatrist I have become increasingly aware that our central task is rehabilitation—that is, helping individuals who are chronically maimed or stunted to use their assets more effectively and minimize their liabilities. In this we are similar to all those who treat chronic illness, and most psychiatric illness is chronic. Occupational therapy obviously plays a crucial part in all rehabilitation efforts, and I have come increasingly to appreciate the role of occupational therapy in our work at Phipps. So I welcome this opportunity to test a few ideas with you.

Although I was happy to receive the invitation to speak to you, I must confess that the topic, "The Therapeutic Use of the Self," somewhat stunned me. "The self" is a term which covers just about all aspects of personality development and functioning, and the adjective "therapeutic" has come to refer to all personal influences which facilitate helpful change. In the hope of carving out an area from this vast field which is particularly relevant to our work and which will keep our discussion within manageable limits, I have decided to focus on the interrelationships of certain perceptual and behavioral aspects of the patient's self, and their implications for the therapeutic use of the therapist's self.

Since the self is an aspect of human nature, we must pause for a brief moment to consider the nature of human existence. Like all living creatures, man is a fragile and transitory organism at the mercy of huge forces which seem indifferent to his fate and which inevitably and eventually destroy him, but he differs from the rest of creation in being aware of his destiny. The poet A. E. Housman has well expressed the human predicament:

> "I a stranger and afraid
> In a world I never made."[1]

Man is always faced with the threat of nothingness, of obliteration, and this is probably the root of the anxiety that all humans feel. In order to combat this anxiety and to gain the positive values of life, man must construct a meaningful world out of his environment. To do this, he learns to make *predictions* as to what the effects of his behavior will be, based on his past experiences. He learns that if he drops a stone it will fall, that if he sticks his hand into a flame, it will hurt him, and so on. These predictions are based on what are called *perceptual constancies;* that is, after he has learned what a stone is, he will perceive anything that looks like a stone as having a stone's attributes, such as heaviness and hardness. After he has seen several different kinds of flame, when he sees a new kind of flame, he will assimilate it to the other kinds and will perceive it as hot. Thus we build up a universe of perceptual constancies, and this is a basic human function.

An important aspect of these perceptual constancies is that they are "time-binding." They are based on past experience, are guided by our present purposes, and imply a prediction or expectancy as to the future. The past experiences may be unique to the individual, or they may be those of the groups to which the individual belongs. The child does not actually have to burn himself to expect that fire will burn him—his mother's alarm when he reached for a live coal may have been sufficient to establish this expectancy.

Let me give some examples to illustrate these points. The perception of a stone involves a set of expectancies based on past experience. This was vividly demonstrated to me when I first met something called pebble candy. This candy looks exactly like little rocks. All my past experience told me that these things were stones; therefore I automatically expected them to be hard and have no taste and probably break my teeth. Even though I knew they were candy, this expectancy was so strong that it was all I could do to taste one. A universal experience is that nearer objects are larger than distant ones; hence, if two similar objects are shown to us, we inevitably perceive the larger one as nearer.

Space perception and pebble candy are examples of perceptual constancies and their accompanying expectancies based on widely shared experiences. Here is an example of how perceptual constancies are influenced by the groups to which we belong. In an experiment subjects were presented with ambiguous stimuli by means of a stereopticon, an apparatus which presents a different image to each eye in such a way that they are superimposed. Thus the observer has three choices; he can see only the left hand image, or only the right hand image, or fuse both of them into a new image. The choice he makes is, of course, not deliberate but automatic, depending on his past experiences and present purposes. To illustrate the role of group influences in de-

termining these choices, some Mexican and American school teachers were shown through the stereopticon superimposed photos of a baseball player and a bullfighter. An overwhelming proportion of the Americans "saw" the baseball play; an overwhelming proportion of Mexicans "saw" the bullfighter.[2]

Finally, perceptual constancies can be determined by strictly personal experiences, as the following amusing example shows. Dr. Hadley Cantril presented to various persons through a stereopticon superimposed pictures of a statue of a Madonna and a statue of a young nude from the Louvre. Among his subjects were two college professor friends of his. As he describes it, one of them first saw a Madonna and Child. "A few seconds later he exclaimed, 'My God, she is undressing!' What had happened so far was that somehow she had lost the baby she was holding and her robe had slipped down from her shoulders and stopped just about the breast line. Then in a few more seconds she lost her robe completely and became the young nude. For this particular professor, the nude never did get dressed again. Then my second friend took his turn. For a few seconds he could see nothing but the nude and then he exclaimed, 'But now a robe is wrapping itself around her.' And very soon he ended up with the Madonna with Child and as far as I know still remains with that vision. Some people will never see the nude; others will never see the Madonna."[3] In this case individual life experiences and purposes seemed to determine what the two professors saw.

I hope these examples make clear that perception is not a passive process by which outside stimuli register upon us as upon a photographic plate, but an active transaction between the person and his environment. The world we live in—the world we perceive—is, in a sense, created by us from a welter of experiences. It consists of a set of *expectancies or predictions,* based on past experiences, selected in accordance with our purposes.

From the fact that each of us constructs a world based on his expectancies, it follows that to the extent that we can influence another person's expectancies, we can affect how he feels, thinks and behaves.

A very striking example of this is to be found in the phenomenon of faith cures. The evidence for these cures is as great as that for anything else we accept as fact. There seems little reason to doubt that faith cures can heal damaged tissues very rapidly under certain circumstances which we still do not understand. The least common denominator of all faith cure situations seems to be an environment in which the atmosphere creates an expectancy that healing will occur. This is true of shrines of miraculous healing which have existed throughout recorded time and in all religions. It also exists in the doctor's office where, because of the doctor's role, the patient expects him to be able to heal him. It has been demonstrated repeatedly through what has been called the placebo effect—the astonishing influence on bodily functioning of an innocuous medication which is offered to the patient as a means of helping him. For example, many dermatologists have shown that painting warts with an inert dye is just as effective a way of healing them as X-ray or surgery. Warts are physical manifestations due to a definite virus. They are obviously not imaginary. Yet the power of the expectancy conveyed by painting the wart blue will in many people be sufficient to produce a change in the skin so that the virus can no longer take hold.

It would take us too far afield to discuss the ramifications of the placebo effect for medicine and psychotherapy.[4] I use it merely to illustrate the tremendous importance of expectancies in influencing our feelings, behavior and bodily states.

So far I have not distinguished between the world of things and the world of people in describing how we carve a meaningful world out of the chaos of stimuli impinging on us by constructing perceptual constancies and expectancies. In order to get on with the topic of the therapeutic use of the self, for the rest of this talk I shall focus exclusively on the personal world. Here the major division we make is between a group of phenomena labelled "myself" and another group labelled "other persons." The importance of a person's notion of his "self" in influencing his feeling, thinking and behavior has long been recognized. Unfortunately, each of us possesses not one self but several. The essayist and novelist, Oliver Wendell Holmes, just ninety-nine years ago in "The Autocrat of the Breakfast Table" expressed this point charmingly:

> "It is not easy, at the best, for two persons talking together to make the most of each other's thoughts, there are so many of them . . . When John and Thomas, for instance, are talking together, it is natural enough that among the six there should be more or less confusion and misapprehension . . . I think . . . that there are at least six personalities distinctly to be recognized as taking part in that dialogue between John and Thomas.
>
> THREE JOHNS
>
> 1. The real John; known only to his Maker.
> 2. John's ideal John; never the real one, and often very unlike him.
> 3. Thomas's ideal John; never the real John, nor John's John, but often very unlike either.
>
> THREE THOMASES
>
> 1. The real Thomas.
> 2. Thomas's ideal Thomas.
> 3. John's ideal Thomas.

"Only one of the three Johns is taxed; only one can be weighed on a platform-balance; but the other two are just as important in the conversation. Let us suppose the real John to be old, dull, and ill-looking. But as the Higher Powers have not conferred on men the gift of seeing themselves in the true light, John very possibly conceives himself to be youthful, witty, and fascinating, and talks from the point of view of this ideal. Thomas, again, believes him to be an artful rogue, we will say; therefore he is, so far as Thomas's attitude in the conversation is concerned, an artful rogue, though really simple and stupid. The same conditions apply to the three Thomases. It follows, that, until a man can be found who knows himself as his Maker knows him, or who sees himself as others see him, there must be at least six persons engaged in every dialogue between two . . . No wonder two disputants often get angry, when there are six of them talking and listening all at the same time."[5]

For our purposes it will be sufficient to distinguish between three "selves": the acting self, the perceived self, and the ideal self. Since there must be something which perceives and acts, we have to postulate another self—the "real" self "known only to his Maker," to use Oliver Wendell Holmes' phrase. But he is beyond my reach, so I shall say no more about him.

We are, of course, not born with a full set of selves but develop them through our transactions with other people and the successes and failures to which these lead. The infant at first is simply a bundle of more or less unrelated interactions with his environment, and his behavior is met by a corresponding variety of responses from others. He cries and is fed. He moves his bowels and is diapered. He smiles and people smile back. Gradually there emerges out of this welter of behaviors and responses a set of *roles*—that is, consistent and enduring ways of behaving which are elicited by certain situations having something in common. Each of us has many roles, each consisting of a different set of actions. A man who plays the role of the autocratic boss in the office may play that of a henpecked husband in the home. A child who is a terror on the playground may be a docile mama's boy at the supper-table. The sum total of the roles with which we respond in different situations may be termed the *acting self*, the self we present to others. Ideally this self is both flexible and self-consistent; that is, we are able to modify our roles to fit the demands of the different situations in which we find ourselves. But also underneath them all we remain recognizably ourselves. They all have a common core. Furthermore, ideally the roles which make up the acting self are appropriate to the different situations. The person is a good boss in the office and a good father at home. That is, he carries out his roles in such a way as to yield the maximum satisfaction for himself and for those with whom he is interacting.

Each of an individual's roles implicitly demands a *reciprocal role* from other persons which tends to reinforce it. The henpecked husband is reciprocal to the domineering wife; the autocratic boss to the submissive employee. Of course, others do not always respond in the way the role calls for, but they do respond in some fashion.

In using terms such as role and acting self, I am trying to emphasize that our behavior always has an audience, which responds actively to it. The terms should not be taken to mean that the person puts on an act deliberately. Roles are assumed automatically and unconsciously.

A person cannot directly perceive his own acting self. What he does perceive is the responses of others to the roles he plays. Other persons are, as it were, a set of mirrors reflecting back our acting selves, with more or less distortion. These images gradually fuse to form a *perceived self* and an *ideal self*—what I am and what I would like to be or should be.

The child, for example, whose parents regard him as basically good and well-meaning will usually grow up to perceive himself as this sort of person. The child who feels unwanted and is made to feel wicked and evil may grow up overburdened with a sense of guilt. That is, he perceives himself as evil.

The perceived self emerges somewhere in childhold. Richard Hughs in that remarkably perceptive book about children, *A High Wind in Jamaica,* describes how his heroine, Emily, at the age of 11 suddenly becomes aware of herself:

"And then an event did occur, to Emily, of considerable importance. She suddenly realized who she was . . . She had been playing houses in a nook right in the bows . . . (Emily is on a ship) and tiring of it was walking rather aimlessly aft, thinking vaguely about some bees and a fairy queen, when it suddenly flashed into her mind she was *she*.

"She stopped dead, and began looking over all of her person which came within the range of her eyes. She could not see much, except a fore-shortened view of the front of her frock, and her hands when she lifted them for inspection; but it was enough for her to form a rough idea of the little body she suddenly realized to be hers.

"She began to laugh, rather mockingly. 'Well!' she thought, in effect: 'Fancy *you*, of all people, going and getting caught like this!—You can't get out of it now, not for a very long time: you'll have to go through with being a child, and growing up, and getting old, before you'll be quit of this mad prank!'

. . . . . .

"Well, then, granted she was Emily, what were the consequences, besides enclosure in that particular little body . . . and lodgement behind a particular pair of eyes?

"It implied a whole series of circumstances. In the first place, there was her family, a number of brothers and sisters from whom, before, she had never entirely dissociated herself; but now she got such a sudden feeling of being a discrete person that they seemed as separate from her as the ship itself. However, willy-nilly she

was almost as tied to them as she was to her body. And then there was this voyage, this ship, this mast round which she had wound her legs. She began to examine it with almost as vivid an illumination as she had studied the skin of her hands. And when she came down from the mast, what would she find at the bottom? There would be . . . the whole fabric of a daily life which up to now she had accepted as it came, but which now seemed vaguely disquieting. What was going to happen? Were there disasters running about loose, disasters which her rash marriage to the body of Emily Thornton made her vulnerable to?"[6]

In this passage the emphasis is on the discovery of the perceived bodily self. The author singles out two implications of the discovery of one's self which it is well for us to keep in mind. One is that when I become a person, other people become persons, too, and I am aware that they exist and function to some extent independently of me. The other is that as soon as "I" exist as an entity, I can become a target, I can be hurt. The integrity of myself can be threatened. As a result, a great deal of our activity seems to be devoted to preserving the constancy of the perceived self, for the same reason that we try so hard to preserve the constancy of our perceptual environment. The perceived self is our base of operations. It is the concept on which we base predictions as to how our behavior will effect others, so we try hard to hold it steady.

Dr. Cantril has shown experimentally that one's perceived bodily self has much greater constancy than the perceived bodies of other persons. He put glasses on people which distort the human form so that the upper part of the body seems to lean forward with the upper and lower half of his body distorted in length. He found that if a person wearing these glasses looks at himself in a mirror, he sees only minor and detailed distortions; for example, the hands or feet may be slightly misshapen. But when he looks at a stranger, he sees more general bodily distortion plus the appearance of leaning one way or another.[7]

Our perceived self includes various aspects such as physical and intellectual abilities, tastes, emotions, and values and standards. The caretaker of these latter is the *ideal self*—the person I would like to be or feel I ought to be. Against this ideal self I continually measure my perceived self. In the normal person there is enough discrepancy between the perceived and ideal selves to stimulate him to try to better himself. Such a person is self-confident or self-respecting. If a person's ideal self is identical with his perceived self, he sees no room for improvement; he is smug. If his ideal self is too far removed from his perceived self, it no longer acts as an incentive for improvement but instead becomes a source of discouragement. Such a person is self-derogatory; he lacks self-confidence.

We try even harder to maintain the constancy of our ideal selves than of our perceived selves. Morality is based to a large extent on the need to maintain intact one's image of his ideal self. Most of us do not respond to the temptation to steal, however great, because to steal would violate our pictures of ourselves as honest persons. In fact, the need to maintain our ideal self intact may be stronger than the drive for self-preservation. Many millionaires have committed suicide after losing a lot of money although they still have more than enough to live on, because they cannot bear to see themselves as failures. The hero marches off to certain death because he cannot stand the thought of being a coward.

Like the perceptual constancies described earlier, the perceived and ideal selves are based on past experiences and imply expectancies about the future. These expectancies are important determinants of feelings and behavior. Psychiatrists have found that a particularly useful question to evaluate a suicidal risk is "How does the future look to you?" It is the prospect of a hopeless future, more than an unbearable present, which makes life insupportable.

If the process of self-development runs smoothly, the person ends with a self-system which has certain properties. First of all, it shows a balance between flexibility and firmness. His acting self, perceived self and ideal self are all clear and definite, but not so rigid that he cannot adapt to different situations. With respect to his acting self, though he can easily assume the roles demanded by different situations, they are all consistent with each other. Secondly, the perceived self and the acting self are in harmony. The person can reasonably accurately predict how he will respond in different situations and how he will look to others. As a result, his acting selves, his roles, are well tailored to the different environments in which he finds himself. Thirdly, the perceived and ideal selves are optimally close together. The person likes himself pretty much as he is, though granting room for improvement. Finally, since the self-image includes the future, a person with a healthy self-system predicts implicitly that he will be at least as successful in the future as he has been in the past. In short, such a person is self-confident and self-respecting.

So far I have described the healthy organization of the self. It is obvious that many of our patients have pathological self-structures. They lack self-confidence. They cannot predict the effects of their own behavior on others. Their expectancies of the future are often much too pessimistic which leads them to give up in the present. I should like now to discuss briefly how these miscarriages of development of the self come about and then return to a brief description of

some of the major ones as an introduction to a discussion of how the occupational therapist can use his or her self to correct some of these difficulties.

Some of the miscarriages in the development of the human self undoubtedly depend on constitutional factors which we only dimly understand at present and which are of little relevance to our current work. I therefore will pass over them with this mere mention and focus entirely on the role of life experience in leading to pathological self-information. I have suggested that each of us develops his self-picture out of the responses of others to him, especially those who mean the most to him such as members of his immediate family. If a person's parents handle him inconsistently, mistreat him, or derogate him constantly, he cannot develop a consistent and workable self-image. The most damaged persons psychiatrists see, from the standpoint of their self-image, are schizophrenics and the so-called sociopathic personalities. The families of these patients are almost always severely disturbed. As Dr. Theodore Lidz and his colleagues are finding, the parents of schizophrenics were often in a state of constant warfare and the child was the battlefield.[8] Often the dominant parents is of the opposite sex from the child and continually derogates and humiliates the same-sex parent. The mother, let us say, holds the father up to scorn, so the boy, who tends to identify himself with his father, comes to see himself as unworthy and inadequate. The parents of sociopaths are often disorganized, without consistent standards, and treat the child unpredictably. They may be neglectful, over-indulgent, or brutal—not in response to anything the child does, but because of their own emotional state at the time. The child has great difficulty developing any kind of consistent self-image from this welter of unpredictable parental responses to him. Let me hasten to add that this is not the whole story of the etiology of schizophrenia or sociopathy by any means, but it may serve to illustrate how early experiences may lead to maldevelopment of the self.

An important determinant of a pathological self-image which deserves the particular attention of occupational therapists is a physical handicap. The actual nature and extent of the disability is important in determining the person's self-image, of course. But probably more important is how the person perceives his disability. This, in turn, largely depends on how it has been perceived by others important to him—what kind of image they have reflected back to him. Thus a visible handicap, especially a disfiguring one, is apt to be more disturbing to a person's self-image than an invisible one such as a damaged heart. A handicap which a person regards as shameful is much more damaging to the self-image than one that is not. Recently I have been working with a patient faced with eventual blindness because of familial eye disease. Several members of his family are already severely afflicted. Though distressed by the threatened disability, he is much more disturbed by his feeling, which he picked up from his family, that it is a disgrace which must be concealed from others at all costs. He sees himself as marked by ancestral sin, as it were, and this is the major problem. For example, it implies that if others knew of his affliction they would scorn him, and it prevents him from even thinking about rehabilitation, because to do so would require a public admission of his handicap.

Inconsistent or derogatory parental attitudes are bound to arouse much anxiety, because they create a situation which is not only threatening but, what is worse, is unpredictable. There is nothing that creates more anxiety than not knowing what to expect. Mild anxiety is a great stimulus to experimentation and change, but excessive anxiety is paralyzing. The more anxious the person is, the more he clings to his habitual ways of perceiving and behaving. At least they have enabled him to survive, however inadequate they may be, and he cannot risk the danger that might result from changing them. The child's anxiety, therefore, make it very difficult for him to change his pathological picture of himself. Thus, most of our patients are saddled with a self, usually the reflection of attitudes of persons to them in their past, which is not very useful in the present. Because this self is not appropriate to their present condition, they experience failures and frustrations instead of successes in their dealings with others which heighten their anxiety and rivet them even more strongly to their past selves. The poet Robert Burns long ago pled for the power to see ourselves as others see us. Our patients cannot see themselves as others see them, because they see themselves as others *saw* them, and they are unable to shake themselves loose from this image.

The best-known example in psychopathology of not being able to free oneself from the past is the so-called *transference reaction*, with which I am sure most of you are familiar. This simply means that an individual reacts to someone in the present as if he were a significant person in his past. He reacts to a boss as if he were a father; to a fellow group member, as if he were a sibling, and so on.

Three ways in which we maintain the constancy of our pictures of ourselves in spite of experiences which might tend to cause changes are: *avoidance, selective inattention,* and *the self-fulfilling prophecy.*

We tend to *avoid* experiences which would cause us to change our pictures of ourselves. Recently I saw a person who expressed this very bluntly. Whenever things do not go to his liking, he states, he just walks off. But one doesn't have to go to psychopathology to find examples of avoidance. I wonder during the last presidential election how many supporters of Ike listened to Stevenson's speeches. How many of us, who listen to say Fulton Lewis, Jr., also listen to Eric Severeid, or vice versa? Most of us avoid reading or listening to persons whose views disagree with ours.

A somewhat more subtle way of protecting the constancies which we have built up is through what H. S. Sullivan has termed *selective inattention.* We simply do not attend to those aspects of situations which are at variance with our established constancies. To hark back to the example of the nude and the Madonna, both stimuli were present. One man attended to the Madonna and "inattended" to the nude; the other attended to the nude and not the Madonna. In all our personal relationships we tend to single out from the behavior of other persons those aspects which fit our preconception and to ignore those which do not. This, in conjunction with the point I am about to mention, I think is chiefly responsible for the fixity of our self-perceptions.

Not only do we selectively inattend to responses of others which might be inconsistent with our pictures of ourselves, but we tend to act in such a way as to elicit behavior from others which confirms our self-picture. This has been termed the *self-fulfilling prophecy.*

The patient with congenital eye disease clearly illustrates this phenomenon. He cannot see in the dark, so he stumbles at night unless somebody helps him. He does not tell people of his difficulty, so when he stumbles they snicker or laugh or think he is drunk, which confirms his opinion that his disease is shameful and disgraceful. Recently in the group he was able to confess in detail his feelings about his night blindness and became quite moved in so doing. As can be well imagined, nobody snickered; nobody thought it was the least disgraceful; and the group was very supportive. At this moment his self-fulfilling prophecy was not met. On the basis of this experience, in a vacation which subsequently ensued he immediately told a couple whom he and his wife had met about his affliction. Then when he stumbled at night, they understood what the trouble was and did not laugh, and he began to get evidence that people did not regard his blindness as a joke. His behavior up to that moment had been such as to reinforce his prophecy that people would have contempt for him if they knew of his difficulty.

What makes these self-fulfilling prophecies hard to modify is that most of the behavior which elicits them is automatic and goes on outside of awareness. I think of a patient in group therapy who wore a habitual frown and wondered why people seemed to react unfavorably to her. She was quite astonished when the group pointed out that she presented a sulky face to the world. We do not know that we are doing things which cause people to react to us in the way that we expect; therefore, it is hard to change.

Many of our patients have disturbed self-structures. I have suggested that the disturbance starts because parents reflect back to the child an inconsistent or derogatory picture of himself. From this he molds a defective or disorganized self-image and then, because he is anxious, he cannot readily change it. Instead, by such devices as avoidance, selective inattention, and the self-fulfilling prophecy he prevents new experiences from correcting his self-image.

I should now like to turn to three common types of disturbance of the self that our patients present: first, difficulties in the acting self; secondly, difficulties with the perceived self; and, thirdly, discrepancies between the perceived, acting, and ideal selves.

The acting self can go awry in two diametrically opposed ways. Frequently it is too rigid; the patient's repertory of roles for different situations is too limited. Now, the narrower the range of our roles, the more compelling they are in influencing the behavior of other persons. It is practically impossible to deal for long with a person who responds suspiciously no matter what you do, for example, without becoming irritated at him. When he finally succeeds in angering you, this confirms his suspiciousness. This pattern is nowhere better seen than in the paranoid patient, whose chronic hostility inevitably engenders like reactions in others which he then uses to justify his feeling that people are against him. Since the more limited a patient's role repertory is the more likely he is to evoke confirming behavior from other persons, the person with a rigid and limited acting self is apt to become more and more committed to the few roles available to him. Thus he meets increasing failures and frustrations, heightening his anxiety and making it even more difficult for him to change his patterns.

At the other extreme the acting self remains diffuse. The patient remains like the infant in responding too directly to the demands of the different situations in which he is placed. His repertory is so wide that no stable acting self becomes organized. He is like a chameleon.

This difficulty with the acting self leads directly into a very important type of self pathology—the failure of a perceived self, and therefore of

an ideal self, to jell. The patient is confused about who he really is. Patients often express this by saying, "All my life is an act." This difficulty is particularly common in our society for two reasons. The first is that it is such a complex and changing one that we are exposed to many different groups with inconsistent expectancies and value systems. Furthermore, these expectancies may change rapidly in time. For example, the modern male is expected to behave quite differently at work, in his home, in church, and when out with the "boys." The modern woman often finds it very hard to reconcile the roles of housewife and career woman, to name just two. Thus the lack of unity in our culture becomes reflected in our multitudinous acting selves and in a confusion in our perceived selves. To use E. H. Erikson's term, we suffer from *role diffusion.*

The situation is aggravated because our culture places such a high value on pleasing other persons. Fromm has described this aspect of our life brilliantly in his discussion of what he calls the marketing character, by which he means that we have adopted the values of the market place in which saleability, not use, is the main criterion of worth:

> "The market concept of value, the emphasis on exchange value rather than on use value, has led to a similar concept of value with regard to people and particularly to oneself. The character orientation which is rooted in the experience of oneself as a commodity and of one's value as exchange value I call the marketing orientation . . . Like the handbag, one has to be in fashion on the personality market, and in order to be in fashion one has to know what kind of personality is most in demand . . . Since modern man experiences himself both as the seller and as the commodity to be sold on the market, his self-esteem depends on conditions beyond his control. If he is 'successful,' he is valuable; if he is not, he is worthless.
>
> "In the marketing orientation man encounters his own powers as commodities alienated from him . . . Both his powers and what they create become estranged, something different from himself, something for others to judge and to use; thus his feeling of identity becomes as shaky as his self-esteem; it is constituted by the sum total of roles one can play: *'I am as you desire me.'* "[9]

This diffusion of the perceived self and failure to form an ideal self is seen in many patients called sociopathic and in some alcoholic patients, who in a single interview can box the compass in their descriptions of themselves. They will, for example, first say that alcohol is not a problem for them, that they can conquer it easily if they only make an effort; and a few minutes later they will point out how impossible it is to overcome their drinking since they have to associate with people who drink. Or they will brag about how independent they are and how able they are to do without other people, and a little later explain how lonely they are and how much they need people. The fact that they can make these statements without any awareness that they are contradicting themselves strongly suggests that they do not have a perceived or ideal self against which they can measure their statements.

Finally, there are various *discrepancies between the different selves* which plague people. Patients often misperceive the physical attributes of their acting selves. I think of a person who always saw himself as much smaller than his teachers in college. When he returned for a reunion he discovered to his astonishment that he was taller than many of them.

The perceived self may deviate from the acting self in two opposite ways, either of which leads to failures and frustrations. The person may over-estimate his acting self, as in the fictitious example given by Oliver Wendell Holmes of the man who was a bore and thought he was brilliant. More commonly, especially among our patients, he is apt grossly to under-estimate his acting self. He does not appreciate his assets and abilities. The man I mentioned who is threatened with blindness, for example, sees himself when blind as utterly helpless and dependent; though perfectly aware that blind people lead useful, productive lives, this simply does not register with him emotionally. One source of this in our society is related to the prevalence of the marketing character with its emphasis on competition to be liked. This leads each of us to develop quite a skillful acting self; we take each other in quite readily. We accept the other person's acting self at its face value, while at the same time being aware of how much we do not live up to our own acting selves. As a result, we tend to under-estimate ourselves in relation to other people. This becomes clearly evident in group therapy or in any type of group where the emphasis is on free and honest interchange of feelings and ideas. The most common single benefit reported by members of these groups, whether mental patients or captains of industry, is the discovery that other people also have problems, that other people are no better adjusted than they are, that behind their acting selves each has doubts and hesitations.

The tendency to underestimate one's own acting self is related to the final type of discrepancy I want to mention—the discrepancy between the ideal self and the perceived self. This discrepancy is perhaps the most potent source of misery that I have mentioned. It seems as if the more doubts we have about our perceived selves, the more rigid and more lofty we make our ideal selves in a vain effort to compensate for this. For example, a hysterical patient who presents to the world a picture of almost superhuman poise,

charm and forbearance feels herself to be full of hate, and is wretched because of this. Her ideal self demands that she should be full of Christian charity and forgiveness at all times and always in complete control of her emotions. Another patient, a man who is very competent in his work, a good husband and father, is frequently depressed and panicky because he is not living up to his ideal of being utterly independent, a complete he-man who is able to tackle anything that comes along without hesitation and without asking anyone else for advice. The man with the failing sight, although he has many successes in business and in social life, can never accept them as real. From the standpoint of his ideal image, you may recollect, his eye disease is evidence of his moral unworthiness, so he cannot admit his successes. He immediately decides each one was a fluke and goes on underestimating himself. In all these cases the excessive height and rigidity of the idealized image blinds the person to his actual successes, because in comparison with what he would like to be they fall far short. Thus, he is unable to gain self-confidence from his actual achievements. Moreover, the situation is a self-aggravating one. The higher the ideal self, the worse the perceived self seems by contrast, causing the person to raise his ideal self still higher, so that neurotic patients characteristically show what might be called a split self-esteem. On the one hand they feel lower than the low and on the other, secretly and in brief moments, they feel far superior to most other people—a truly miserable state of affairs.

One can sum up these different forms of failure of the self to develop with the word "disintegration." They are all aspects of failure to form an integrated self, expressed either by too great a rigidity of the acting self, inadequate structuring of the perceived self, and discrepancies between the three different selves.

To recapitulate, much of the distress of our patients can be viewed as springing from disorders of their self-systems. As a result of misperceptions of themselves in relation to others, they guide their behavior by incorrect expectancies and predictions, leading to experiences of failure and frustration which increase their emotional difficulties. Their disordered self-systems have grown up through damaging experiences with others and have been maintained and strengthened by a variety of mechanisms such as avoidance, selective inattention and self-fulfilling prophecies.

All forms of psychotherapy, including the psychotherapeutic aspect of occupational therapy, try to reinforce the healthy aspects of the patient's self and help him to modify its flaws. They do this by trying to engage him in new and different interpersonal transactions which will confirm his healthy expectancies and disappoint his pathological ones.

The main therapeutic tool for this purpose is the self of the therapist, and here, at last, I shall address myself briefly to the title of this presentation—the therapeutic use of the self.

The first questions is, how much of the therapist's self is relevant to therapy? I do not know what occupational therapists are taught about this, but in psychiatry there is a tendency to assume that the psychotherapist's total self must be involved if treatment is to succeed. Much has been written about the qualifications of the psychotherapist which leaves the impression that he must be a paragon of warmth, maturity, altruism, able to give freely of himself, acutely sensitive to the feelings of others and so on. Some writers on therapy go so far as to maintain that genuine therapy only occurs when the therapist becomes deeply and personally involved in the process. It seems to me that this is unsound theoretically but, more important, that it is decisively refuted by everyday experience. We all know that the therapeutic skill of our colleagues bears little relationship, within wide limits, to their own maturity, idealism, nobility of soul or sensitivity.

There is no question but that some persons have greater healing powers than others, and that this depends on attributes of their personalities which are ill-defined and probably cannot be taught. Moreover, obviously one cannot play one's therapeutic role successfully unless this aspect of oneself is supported by a reasonably sound self-structure in other respects. A therapist may have personal problems which are so severe as to interfere with his role as a healer, in which case he should certainly seek to straighten himself out by himself submitting to psychotherapy.

But if successful therapy were solely a matter of the therapist's innate gifts or qualities he has achieved through his own psychotherapy, there would be nothing to teach or learn, and a meeting such as this one, for example, would have no purpose.

My own belief is that most of us have enough innate healing potentialities, and are well enough organized to be able to present an acting self to the patient which enables him to achieve a better integration of himself.

If we do not keep our therapeutic role distinct from the rest of ourselves, we run the risk of impeding our therapeutic efficacy in several ways. One is that we may try too hard to help—we may expect too much of ourselves, forgetting that like all skills, those of the occupational therapist have only a certain range of usefulness. This may play right into the exaggerated and unrealistic demands of certain patients, briefly arousing

in them false expectations of a miracle. So they end up more disappointed and embittered. Or it may feed their already excessive dependency and impede the development of a more independent outlook.

More importantly, to the extent that we do not keep our therapeutic role clearly separated from the rest of ourselves, we are at the mercy of the patient who fails to improve. Occupational therapists like psychiatrists are practitioners of a healing art who perceive themselves as help-givers; that is, persons able to relieve suffering and improve the effectiveness of others. If we invest too much of ourselves in this role and cannot carry it out successfully, we become frustracted and react with anger or depression. We are exposed to exactly the same type of damaging failure experiences from which many of our patients suffer, and thereby in the long run become less effective because of our own exhaustion or irritation. Certain types of patients make it very difficult for the occupational therapist to offer help successfully. Patients who fail to improve despite our best efforts and return always with renewed complaints or accusations that we are making them worse are a great trial, because they do not display the behavior which would be reciprocal to our role. Sometimes one cannot maintain the proper role with such patients, and then it may be well to refer them to another person. But the best protection against such patients is to remind ourselves of the limitations of the therapeutic role. Through this we may be able to maintain the objective attitude which represents the best possibility of thwarting their self-fulfilling prophecies that all those from whom they seek help are angry at them and will eventually reject them. In this way we may be able to help them after all.

The therapeutic role of the occupational therapist is confined to trying to bring about modifications in the acting self of the patient. He tries to help the patient modify his expectancies in a limited area of his functioning—the task he is doing—in the hope that the self-confidence thus gained will generalize to other areas of the patient's life. This will lead to modifications of his behavior which will, in turn, elicit different behavior from others. This further strengthens his favorable expectancies, leading to progressive improvement. The point to emphasize is that whatever the occupational therapist's hopes as to the final outcome of this train of events, he is responsible for aiding only in one of its initial steps.

Within these limits, the therapeutic goal of the occupational therapist is the same as that of any psychotherapist; namely, to strengthen healthy aspects of the patient's self-picture and weaken the unhealthy one. The latter is accomplished by acting in such a way as to disappoint his pathological expectancies. The real art of therapy is to do this under such conditions that it will lead to a modification of his expectancies in a healthy direction. For the patient has many ways of maintaining his habitual expectancies despite contradictory experiences. Therefore, special conditions have to be met if the therapist's behavior is to be effective.

First of all, the therapist must act in such a way that the patient perceives him as someone who wants to help and is able to do so. As already mentioned, the expectancy that something helpful is going to happen may in itself be a powerful healing force, as faith cures bear witness. In addition, the patient's faith in the therapist may give him the initial courage to experiment with changes in his behavior, to become more spontaneous and flexible and thereby mobilize his assets more effectively. In any case, it is only if the patient perceives the therapist as an actual or potential help-giver that he will be influenced by the therapist's behavior.

The therapist gets across to the patient that he can be helpful by demonstrating his belief in himself, and in the patient. He demonstrates his belief in himself by showing competence in his role—by doing his job in a self-assured manner. Let me emphasize again, this does not require that the occupational therapist be self-confident with respect to all aspects of himself, but simply that he know his job and show it.

Demonstrating one's belief in the patient's capacity to be helped is a more complex business. How one does this depends on how one sizes up the patient's reactions to praise and blame. Direct reassurance may be the right approach to many—perhaps most—patients, but for some it has the opposite of the desired effect. Schizophrenic patients, for example, are suspicious of praise. They are apt to experience it as an attempt to seduce them into a state of emotional dependency so they can be manipulated and exploited in the service of the therapist's nefarious plans. All of us may experience praise which is given too easily as at best a dubious compliment, because it implies that the praising person does not expect very much of us. So, many patients get more of a feeling of your belief in them if you offer reassurance sparingly, thus implicitly reinforcing their self-confidence. Under special and rare circumstances the best way to convey one's faith in a patient may even be to get angry at him. If it is clear that the anger is directed, not at his total self, but at his acting self of the moment and that it is based on the therapist's conviction that the patient can easily do much better, then it can be supportive.

In addition to conveying his ability and desire to be helpful, the therapist increases his chances of disappointing the patient's pathological expectancies by striking the proper balance between *clarity* and *ambiguity* in his behavior. Let us consider each of these aspects in turn. The therapist must act clearly and consistently because it usually takes a long while for behavior which contradicts a patient's expectancies to break through into the patient's awareness. Moreover, consistent behavior in itself may disappoint a major expectancy of many patients who display a variety of inconsistent—or even conflicting—behaviors. They may express utter discouragement one moment, over-optimism the next; alternate between resentment and gratitude; demand a great deal of help or insist on doing it themselves. And they implicitly expect from the therapist the reciprocal responses to these behaviors. Once the therapist has decided what his most effective role should be with the patient, he should maintain it consistently. This not only disappoints a lot of the patient's expectations, but gives the patient a model of steadiness which may help him to settle down.

Consistency, however, does not mean rigidity, but rather *predictable flexibility*. The occupational therapist must be flexible in the sense of changing his behavior to fit the needs of different patients and will want to modify his behavior in keeping with a particular patient's progress. The essential points are that all of the therapist's behavior be such that the patient can perceive it as consistent with the goal of offering help, and that it be predictable. However wide the range of responses that a therapist offers a patient, the patient should have the feeling that if he acts in a certain way, the therapist will respond in a certain way. In this way the patient has a chance to build up new expectancies as to the effects of his behavior which will tend to counteract his habitual faulty ones.

The ideal of consistency, finally, must leave room for *spontaneity*. The therapist obviously should not function like a machine, and an important aspect of demonstrating confidence in one's role is being able to be spontaneous at times. The person who obviously calculates every move inevitably conveys the impression of being unsure of himself. Moreover, we hope our patients will develop more spontaneity, and can help them to achieve this by presenting ourselves as a model in this respect.

I have stressed the importance of presenting a clear and consistent picture of oneself to the patient. It now remains to round out the story by adding that a certain degree of *ambiguity* may also be appropriate. To the extent that everyone fears the unknown, an ambiguous situation is anxiety-provoking. If the patient cannot figure out what is expected of him, he may become so anxious that he is even less capable of learning than usual. On the other hand, with certain patients ambiguity has a diagnostic value in that it helps us to determine how the patient copes with stress. From the therapeutic standpoint it tends to increase the patient's involvement in the situation. He is forced to engage himself in order to cope with the uncertainties and deal with them. Finally, it can help his self-confidence if he copes successfully with the ambiguity and manages to create out of it an adequately structured situation. Thus the optimal balance between clarity and ambiguity depends on how well-organized the patient's self-system is. Schizophrenics and sociopaths, whose selves are chaotic, usually benefit only from crystal clear, definite behavior on the therapist's part; mild neurotics may profit more from being left to their own devices.

It should be apparent from this discussion that all generalities about the therapeutic use of the self should be regarded with suspicion. In the last analysis, the therapist's success in acting so as to usefully disappoint the patient's expectancies depends on his diagnostic acumen with respect to the patient concerned, and the repertory of behavior at his command. His aim, always, is to respond differently enough from the patient's expectancies to force the patient to take another look as it were, but not so differently that the patient perceives it as totally irrelevant to his behavior. Furthermore, it must be different enough to arouse an optimal amount of anxiety in the patient, since this is a powerful stimulus to learning, but not so different as to arouse excessive anxiety, which is paralyzing and serves merely to reinforce the patient's original behavior.

Let me, in conclusion, try to pull this rather complicated presentation together. Many of our patients have faulty self-structures, which contribute significantly to their difficulties. I have tried to describe some of these faulty selves and how they may arise, stressing particularly the role of expectancies, based on past experience in determining how we see the world and how we behave. One of the tasks of the occupational therapist is to use himself to help the patient develop a more workable self of his own. This requires, first of all, that the therapist make a correct diagnosis, that he understand what is going on, and one aim of this presentation has been to offer a framework for thinking about problems of the self. To use himself effectively the therapist must also have a clear realization of his own abilities and limitation. He must have confidence in his methods, but should not expect them

to work miracles, and he must set limits to his own self-involvement in his therapeutic efforts.

In trying to use himself therapeutically, the occupational therapist has two general goals. The first is to get the patient to make an emotional investment in the therapeutic situation—to perceive it as important to his welfare—since if he does not, nothing the therapist does will make any difference. The second goal is to reduce the patient's anxiety, or raise his self-confidence, to the point that he can dare to take a fresh look at himself, and begin again to profit from new interpersonal experiences. Aspects of the therapist's behavior which can help to achieve these goals are his use of reassurance, the clarity or ambiguity of the treatment situation he creates, and the consistency, flexibility, and spontaneity of his actions.

REFERENCES

1. *Collected Edition of the Last Poems of A. E. Housman.* New York: Scribners, 1937.
2. Cantril, Hadley. "Perception and Interpersonal Relations," *American Journal of Psychiatry,* 114:119-126, 1957.
3. *Ibid.*
4. Rosenthal, David and Jerome D. Frank. "Psychotherapy and the Placebo Effect," *Psychological Bulletin,* 53:294-302, 1956.
5. Holmes, Oliver Wendell. *The Autocrat of the Breakfast-Table.* New York: The Heritage Press, p. 46-48, 1955.
6. Hughes, Richard. *A High Wind in Jamaica.* New York: Modern Library, p. 188-195, 1932.
7. Cantril, Hadley, *op. cit.*
8. Lidz, Theodore, Alice R. Cornelison, Stephen Fleck, and Dorothy Terry. "The Intrafamilial Environment of Schizophrenic Patients: II. Marital Schism and Marital Skew," *American Journal of Psychiatry,* 114: 241-248, 1957.
9. Fromm, Erich. *Man for Himself.* New York: Rinehart and Co., Inc., pp. 68-73, 1947.

SYNTHESIS

WILMA L. WEST, O.T.R.

One day, just about a year ago now, a friend of mine passed her fearsome fortieth birthday. With little reason but perhaps in characteristic human fashion, she waited throughout the day of the event itself for something to happen, some sign that life might truly be about to begin. Her attitude was essentially passive, one of casual observation, one with an air of expectancy of things to come, and one lacking the personal initiative that might have served as the essential catalyst to action in otherwise predisposing circumstances. Of course nothing happened, either on the great day itself or during the weeks and months that followed. Gradually, our friend came to realize that this absence of special event in the face of essential passivity was considerably more in the nature of things than would have been the case had anything significant actually occurred. For our friend well knew, and long before she reached the supposed criterion age of forty, that there is little in life which begins or proceeds or ends except as it is brought about or in some way influenced by the positive posture and performance of those privileged to live it.

In March of this past spring, occupational therapy passed its fortieth birthday. This occasion went unobserved, probably even unrecognized by the majority but, had one observed the members of this profession whose life then, according to the popular phrase, was just beginning, one would have noted some similarity between our general professional attitude and that of the friend previously described. If you read at all, you know that this observation is shared by other commentators on the contemporary OT scene, and if you think and reflect about what you are doing and why, you perhaps have come to some of the same conclusions. Therefore, in casting about for a theme and message that might provide a fitting close to this, our fortieth annual conference, I thought it might be interesting to examine the origin of this attitude in terms of our historical development, the effect it has had on our present status, and some implications it reveals for our future course. This will go a bit beyond a synthesis of this one meeting and attempt to sketch a short professional biography that might be called "The Life and Times of Occupational Therapy."

Although we are more concerned with what lies ahead than with that which has gone before, the student of history tells us that the present is seen with enlightened clarity and the future planned with more sound perception if we pause to consider relevant aspects of the past. Let us, then, enumerate just a few of the milestones in our development. In opening these windows on our heritage, we gain renewed appreciation for our assets and deeper understanding of the liabilities and mounting obligations against which we may hope the grace of further credit will be extended.

Our birth in 1917 was a part of America's effort in the First World War. Our professional predecessors were first nurses and later teachers. Our function, originally to divert the sick, subsequently evolved as quasi-specific treatment for

various types of functional and organic disorders. Our educational programs kept pace with demands for our clinical service and added new and longer courses to improve and extend our base of preparation. Numerically, our growth during these early childhood years was slow, but clinically and educationally, our progress was sufficiently creditable to bring professional recognition and status.

Such was accorded us on coming of age. In 1935, the eighteenth year of our life, the American Medical Association established standards and procedures for the accreditation of our schools. Four years prior to this time, our own national organization had established a registry for examining and certifying professional competence. Both of these evidences of our maturation have been strengthened in the intervening years and maintained to the present date. Thus our teens were marked by achievements possibly beyond our tender years.

Our twenties were to prove as productive as only turbulence and trying times can make most human endeavor. Before we were twenty-five, the Second World War had started and new demands for both numbers and types of service faced us. As many endeavors grow through challenge and adversity, our profession responded with total effort and considerable accomplishment. Both military and civilian services expanded to educate and employ greatly increased numbers of personnel and force us into new roles and additional functions utilizing potentials not previously developed. With the first outside grant of financial support in its history, our national organization instituted a program of educational research and expanded its scope of traditional membership services. In 1947, we celebrated our thirtieth birthday with a new national registration exam, the first textbook and the first master's degree course in our field, and publication of our own official organ.

The most recent decade of life, our thirties, has been equally impressive, though for different reasons. Riding the wave of post-war enthusiasm, we entered this era with a cooperative vigor and vitality astonishing to professional activity. Committees were formed on a broad range of subjects and accounted for most of our professional studies and publications. Curricula were revised to incorporate newer knowledge and experience, and graduate and special courses were offered in response to demands of those in the clinical field. As public and professional interest in rehabilitation grew, we utilized generous grants from federal and private agencies to sponsor recruitment effort, selection studies, scholarship assistance and numerous special institutes, workshops, conferences and short courses. Various other projects are in advanced planning stages, including studies of our academic curriculum, student affiliation programs, treatment and testing media, and other areas vital to our professional development.

Here endeth the history. Now, there is one activity characteristic of the latter part of this most recent period which brings us up to date and has bearing on our present status and future course. This is the series of "group thinks" of which this institute-conference is the eighth in the past two years and through which we have undertaken a critical self-analysis of both general and specific areas of our profession. Through this form of cooperative thinking studies have been made on professional education and practice in rehabilitation, techniques of instruction and administration, the basic approach in occupational therapy, group dynamics and the team approach in rehabilitation, prevocational techniques and media, essentials of treatment, function and preparation of the psychiatric occupational therapist and, finally, on the topic of this past week, interpersonal and group relationships.

We are still rather close to this most recent experience to permit sufficient perspective on specific professional values we may have attained. We can, however, make observations on our personal gains from this "new look" institute-conference that has offered maximum individual participation and the exchange of knowledge and views with our colleagues. Hopefully, each of us witnessed some new or adapted treatment technique at "the fair," gained insight in the area of relationships during the institute, and benefited from the suggestions discussed in the sessions on patient evaluation. We have been participants or spectators according to our needs and our abilities and we have grown from the experience in essentially like manner and measure.

Professionally, we may make further observations based on analysis of the recommendations emanating from six previous efforts of this type for which proceedings or summaries have been published. In all, a total of 73 separate recommendations resulted from the 27 days of deliberations in which 333 occupational therapists participated through the one NIMH and five OVR institutes held in 1955-56. A breakdown of the distribution among categories of these recommendations shows that eighteen were referred to our national association, twenty-nine to the schools, thirteen to the student affiliation centers, two to state associations, one to treatment centers, and ten to practicing therapists. There is an obvious trend in this material from which we can draw inferences and suggest some comments on implications for the future.

Let's consider a few of the specific recommendations in each of the first three categories.

Of the eighteen referrals to the national association:

Three were in process prior to the referral:

1. Seeking a grant to study the use of vocationally-related activities.
2. Providing for recognition of aides.
3. Conducting conferences with institute-type programs.

Action on *two* was initiated within a year following the recommendations:

1. Establishing an interdisciplinary study group in psychiatry.
2. Appointing a committee to develop the concept of the basic approach in occupational therapy.

Four were referred to association committees:

1. Study and implementation of the basic approach in occupational therapy.
2. Study of an effective way of achieving greater exchange between schools and student affiliation centers.
3. Interchange of school and clinical personnel for improved standards of education.
4. Recognition of aide personnel and provision for additional assistance and training.

Four were considered more suitable matter for study by individual therapists and treatment centers than by the national organization:

1. Standardizing prevocational tests.
2. Developing measures of the emotional and social needs of patients.
3. Compiling a guide book on group techniques.
4. Developing basic methods of record-keeping.

Five are still under consideration:

1. Clearer definition of the responsibility of occupational therapy as related to vocational needs of patients.
2. Standardization of occupational therapy procedures on school and clinical levels.
3. Holding an institute for occupational therapists and vocational counselors on methods of testing physical and work capacity of patients.
4. Analyzing our present treatment media for potential transfer to industrial situations.
5. Studying the techniques of communication to further improve our methods of interviewing, recording and reporting.

From the *twenty-nine referrals to the schools,* it could be concluded that positive action on all would result in a ten-year curriculum. Undoubtedly, however, several will be implemented wherever possible because of the proven need for them, e.g.:

Adding courses in

1. Group dynamics
2. Interpersonal relationships
3. Therapeutic use of self
4. Testing activities of daily living
5. Principles of splinting and bracing

Here, too, some of the procedures recommended were in effect in several schools prior to the referral, e.g.:

1. Earlier patient contact through clerkships
2. Utilization of councils for integrating academic and clinical teaching.
3. Improved methods of selection
4. Provisions for workshops and short courses

The *thirteen referrals to student affiliation* centers covered a broad range of subject matter, mostly stressing the need for closer correlation with schools and offering students more vital learning experiences in several specific areas. The degree to which these recommendations are effected will depend on the action of the student affiliation committee and the individual directors of affiliation programs.

But it is the latter three categories of referrals —those to state associations, treatment centers and practicing therapists—with which I am primarily concerned and on which I would like to express some thoughts. First among these is the observation that scarcely eighteen per cent of the total number of recommendation was related to the individual practicing therapist. I think this has considerable significance. It is, of course, quite human for us to think in terms of criticism of the other fellow, whether that be the office staff, national committees, school personnel, clinical directors or others, and to pass the burden of responsibility for action to someone else. In this connection, I could not help thinking about an exchange of letters I recently had with Mr. Sidney Tickton of the Seventh Company. This past spring, there was published a preliminary report of that company on the salaries of personnel in the rehabilitation field which resulted from a survey conducted in cooperation with several national organizations, including our own. Being as interested in this subject as the next person and acting on the general invitation to comment on the report, I wrote Mr. Tickton, expressing interest in findings of the study and the hope that his organization would propose definitive action to adjust existing discrepancies between education and salary of rehabilitation personnel. The very pleasant but pointed reply which I received almost by return mail read, in part, as follows:

". . . I was very pleased to have your kind letter" etc. . . .

"The National Rehabilitation Association has asked me to prepare a speech on the matter of salaries and personnel to be delivered at their meeting in October. What I'm going to have to tell them in the speech is that raising salaries is very much a 'do-it-yourself' program. People in the rehabilitation field with the support probably of non-partisan citizen committees will have to carry the ball.

"This is what has happened in education during the past decade . . . The same thing has to be done in rehabilitation if we are to staff, in the period ahead, the new hospitals and centers we have been building . . ."

I have referred to this correspondence because it graphically illustrates my first point concerning our regrettable tendency to think always in terms of letting someone else do that which is really our job. In this particular instance, as in many others, who else is concerned as much as we? Who stands to benefit other than ourselves? Who knows our qualifications and our services and can equate them with role and responsibility? We may well wish that others would do this for

us, but we should know that such seldom happens.

And this applies in matters other than those concerned with salary. It is equally true in such major areas of our field as organization, education and practice. With reference to the recommendations resulting from previous institutes that we have just listed, some of these obviously were inappropriately referred to others, whereas they actually are each individual therapist's responsibility. I refer particularly to those listed as more suitably the job of the practicing therapist—e.g., standardizing prevocational tests, developing basic methods of record-keeping, studying techniques of communication, etc. Thus, it would seem that in considering any professional problem we might first ask ourselves a basic question: "What can *I* do about this?" and, second, not "To whom can I refer this?" but: "Who else can help me with it?" With the greater sense of personal responsibility implied in this attitude, rather than bucking our problems and recommendations on to someone else, we would show a more realistic approach and have far greater chances for professional achievement; because, whereas there are only some 600 occupational therapists implementing the work of our national office, committees, schools and affiliation centers, our total working population numbers over 3,000. Marshalling this kind of force in any cause should make problem-solving infinitely easier than expecting a smaller number to do things for us.

The second implication in these recommendations is even more significant than the first. This involves their specific content more than the sources to which they have been referred for action. The verbiage of the overwhelming majority of them suggests that we "study concepts, compile guide books, conduct institutes, survey practices, promote cooperation, add, revise or delete courses, improve communications," etc. A scant half dozen suggest that we "standardize techniques, develop methods, and evaluate procedures," thus using terms a little more specific to clinical performance and less concerned with general professional principles. Only one recommendation—one of seventy-three—approaches the crux of the real challenge which faces occupational therapy today and this was rightly among the group referred to the individual practicing therapist. I am not going to quote it at this point, but I hope its general content may be revealed in the balance of these remarks.

Why do I seemingly de-emphasize the other seventy-two recommendations and single out one all-important issue? I have tried to indicate that many of the other suggestions and referrals have intrinsic value and that a number of them are in process or under study at the present time. This provides the assurance we like to feel that someone is doing something about some of the problems identified and solutions suggested. But we must not evade the greater implications here —that of our own individual and personal responsibility—and this responsibility must be assumed with specific and direct reference to clinical performance. I would differentiate the character and underscore the importance of this area of clinical performance by referring to it as the central nervous system of occupational therapy and contrasting it with the periphery of our interests and functions to which most of our past effort has been directed and most of our professional achievements to date must be credited.

What lies at the core of this "central nervous system" of occupational therapy? I believe it is our method. And since we have identified ourselves with the science of treating disease and disability, this must be further qualified as scientific method or, in our case, the lack of scientific method. I don't know the origin of our claiming immunity from the responsibility for determining cause, procedure and effect in our work that devolves upon all who would be a member of the fraternity of science, unless it be found in our desire to also belong to the society of art. If so, this is merely confusion, for such artistry as we may possess is exhibited in the manner in which we apply our method. Surely no better example of the fact that these two can and must be co-existent may be cited than that of the surgeon whose art in performing the most intricate repair could scarce prevail were it not based on the most precise and highly defined method of science and medicine.

To apply the scientific method to occupational therapy, we must first understand what that method is. Second, we must apply it in accordance with accepted procedures. And third, we must integrate results into a formulary of proven principles and practice which will justify the professional status granted occupational therapy twenty-two years ago but in fact not yet earned. Occupational therapy has long been called "a pioneering profession." I wonder if this term should still apply as we attempt to demonstrate a maturity more becoming to our forty years? It would seem that such a designation was quite suitable for the years of our early growth and development when our performance naturally resembled that of the child who gropes through trial and error toward solution of each new problem confronting him. Now, however, as an adult, we should have learned organized methods of behavior and performance, methods which are incorporated into a body of science that defines and delimits our discipline.

Let us consider briefly three steps suggested. The first requisite stated was knowledge of the scientific method. Regardless of technical definitions, we know it is the best technique yet devised to establish stable beliefs. Although not infallible, it is self-corrective in that its accepted procedures demand the noting and correction of errors through continued application and testing. The propositions which a science subjects to study are, through experiment, either confirmed, modified or rejected in accordance with the evidence. Hence, by not claiming more than the evidence warrents, scientific method succeeds in obtaining a greater degree of logical certainty than any other method yet devised. I like to think of the scientific method defined in a sort of reverse parallel of the basis of American law: thus, although we believe a man is innocent until he is proven guilty, we hold a theory is not fact until proven true.

Our second essential in utilization of the scientific method requires that we apply it in accordance with accepted procedures. There are three elements inherent in such application: facts, hypotheses and evidence.

The method of science is to discover what the *facts* truly are, but apparent facts will often be tempered by further analysis. For example, from the observation that both flame and dry ice produce the same sensory experience, we cannot, without error, conclude that the temperatures of the two substances are the same. Thus, untested impressions do not qualify as facts until verified through rational explanation of how and why. The desire for knowledge is more widespread than is generally recognized. We are told that it has its roots in an innate animal curiosity which we see evidenced in the perpetual questions of children and the less justifiable but equally perpetual gossip of adults. But while the desire for knowledge appears great, it is seldom strong enough to sustain critical inquiry. Rather, we tend to be more interested in the results per se than in the method whereby those results are obtained and their truth continually tested and qualified. Thus we in occupational therapy who are unwilling to accept the challenge to explain the how and why of our method perhaps merit classification in the "wine and green mold stage of pre-scientific effectiveness" suggested by one writer in a recent issue of our Journal.[1]

There is no sharp line dividing fact from *hypothesis*—the second element in application of the scientific method. Hypotheses may be thought of as possible connections between actual or supposed facts. They are suggested by something in the subject matter under investigation, or by knowledge of other subject matter, and are required at every stage of inquiry. Their number is limited only by the imagination of the investigator and they may be negative or positive. They may change, during an inquiry, to facts and back again to hypotheses, or they may have to be discarded in favor of substitute propositions dictated by the course of the investigation. Through the process of deduction and the logic of probable inference, hypotheses may become facts or they and the assumed facts they were designed to test may be disproved.

The third element in application of the scientific method is *evidence*. The single most identifying characteristic of the scientific method is its questioning of whatever lacks adequate evidence in its support. The intensity with which a belief is held is no guarantee of its truth. Thus, when our most cherished beliefs are challenged and we react as when one dear to us is insulted, we must nevertheless be ready to abandon theories incompatible with the evidence. Fear of offending established dogma has been an obstacle to growth of the physical sciences and failure to subject our traditional theories and practices to the test of science is a hindrance to professional respectability in occupational therapy.

The third step suggested as a concluding procedure in establishing the science of our discipline is an inevitable corollary of the first and second. For if we can but acquire a knowledge of the methods of science and persevere in applying them, we will assuredly record, interpret and utilize the data thus revealed. It is to our credit that, as a professional group, we have learned through education or experience more about this concluding activity than we know about those which necessarily precede it. The quantity and quality of our professional literature, though still scant and in the class of the student rather than the scholar, has undeniably improved in the past few years and will help us raise both the speed and level of our method if given a chance. Similarly, that method can be acquired by those who would learn—through study, reading, observation, the help of interested and willing colleagues, and, primarily, our own attitude and initiative. As each individual among us exerts the effort befitting a professional person, gradually the theories we assert will become less vague, the range of their application better known, and their compatibility with proven fact more certain. Much of the "common sense" according to which we have traditionally operated is more in the nature of a collection of information than a system of sound, inter-related theories and procedures that is the ideal of science.

We have attempted, in the past few minutes, a perhaps too ambitious consideration of some of the "traditions that surround and pressures that engulf us. I think, however, that if we listen, we must hear such records as I have tried to play from our life to date; if we look, we must see that the times in which we would exist require a more scientific method; and if we speak, it must be in tones of reason and wisdom rather than platitudes and propaganda based on assumed fact, untried hypotheses and inadequate evidence.

And what has all this to do with the institute-conference we are here closing? I see it as quite directly related to the subject of our week's study, in this way: In areas of *group relationships,* we have achieved some success; for example: our professional organization is evident on the national scene, our schools are incorporated in the framework of college and university education, our departments are a part of the facilities devoted to care and treatment of the handicapped, and our individual members are included on the rehabilitation team. But, at this final and most important level, that of the individual therapist, where the *one-to-one relationship* is the determining factor, we still lack strength; for example: we as individual therapists are not as often on the team or on as many different teams as some of our colleagues. Even when we are present, our contribution is often neither sought nor utilized; our services are expendable in many situations, never requested in others. Thus, I see this area of interpersonal relationships as being one of the most important in which we must continually strive for more effective development: in our relationship with the patient, the physician, the administrator and the individual member of each of the allied disciplines with which we work.

As we conclude this institute-conference, advance into our fortieth year and look ahead to the life we are promised is about to begin, let us try to do so with a philosophy that will blend a mature approach with dynamic action. Thomas J. Watson, that sage of the International Business Machines Company, has made popular a one-word caution: "THINK!" We know we can never over-exert ourselves in this important function and responsibility. But, as I have tried to point out, we have pursued this habit, in the past few years, to the point where we can now clearly see areas which demand action suited to the thought. In charging the Commission on Chronic Illness with the need for solving problems in that area, Leonard W. Mayo coined a dynamic combination of phraseology and philosophy when he said: "Let us *think* like men of action; let us *act* like thoughtful men."

Recognizing the wisdom of each element of this advice, therefore, we might add a new one-word dimension to our resolution for the life ahead: "ACT!" And, in recognition of the emphasis in our past activity and the clearly-indicated demands on our future, let's go further and say: "HAVE THOUGHT—WILL ACT!"

REFERENCES

1. Meyerson, Lee. "Some Observations on the Psychological Roles of the Occupational Therapist, "*American Journal of Occupational Therapy,* XI:3 (May-June), p. 131, 1957.

Reviews

A SIMPLE, READILY AVAILABLE FINGER SPLINT. William L. White, M.D. *The Journal of the American Medical Association,* 165:8 (October 26) 1957.

Specifications of the ideal finger splint are reviewed: simplicity, ready availability, malleability, and strength sufficient for immobilization.

A source for such a splint is suggested: the metallic bands encircling bottles of intravenous fluid. Specific directions for construction of this splint with supportive dressing are presented by Dr. White, materials employed in addition to the band including simply adhesive tape, gauze, and a roller bandage.

This type of splint is felt to be effective for superficial lacerations, fingertip amputations, and distal phalanx fractures; it is not recommended for immobilization following nerve or tendon repairs, for joint disorders or digital fractures.

—D. R. Street, 1st Lt., AMCS.

TRAUMATIC AMPUTATION OF FINGER TIP. Stanley Simon, M.D. *The Journal of the American Medical Association,* 163:12 (March 23) 1957.

Concerning immediate definitive treatment in traumatic amputations of the finger tip, it is pointed out that measures should be taken to prevent the formation of neuromas in the digital nerves in the amputation stump. With the patient under general anesthesia and with tourniquet control, the digital nerve stumps, it is felt, should be dissected free and sectioned under tension to retract from the wound so that scar tissue will not adhere to the digital nerves and result in painful digital neuromas. This should be accomplished prior to attempting a skin graft, either full-thickness or pedicle graft.

—D. R. Street, 1st Lt., AMCS.

RETRAINING THE DISABLED OLDER PERSON FOR PURPOSEFUL LIVING. Glenn Gullickson Jr., M.D., and Frederic J. Kottke, M.D. *Geriatrics,* 11: (November) 1956.

This paper presents some of the common problems and procedures necessary in geriatric rehabilitation and discusses rehabilitation of patients with hemiplegia and degenerative joint disease. It has been estimated that 17 per cent of persons over 65 can be expected to have mental or physical conditions that will disable them for three months or longer. It is for this group of persons with chronic progressive diseases that rehabilitation programs are necessary.

Occupational therapy should be an integral part of the rehabilitation programs to help maintain function, pre-

serve morale, and reduce the element of fear of activity in patients with hemiplegia, degenerative joint disease and other chronic diseases. The use of short activity periods with intervening rest periods is the suggested routine, and constructive, purposeful activities are preferred.

The over-all rehabilitation program must include psychologic rehabilitation as well as physical. The patient must be helped to adapt himself psychologically to any remaining disability, in order that emotional disturbances may be resolved, and encouraged to develop his remaining potentialities and capacities.

—Virginia M. Barr, Lt., AMSC (OT).

FOREIGN LETTERS. *The Journal of the American Medical Association*, 165:10 (November 9) 1957.

FRANCE: "Dupuytren's Contracture." De Seze and Debeyre present the results of treatment of 70 cases of Dupuytren's contracture—first, second, and third degree—by means of local injections of hydrocortisone into the nodules and palmar fascia. Supplementing the injections, to aid in breaking up adhesions, traction on the phalanges was employed. In all first degree contractures definite improvement was noted; in the second and third degree cases, 44 per cent reported excellent results. In only four patients so treated was there no improvement.

SWEDEN: "Ultrasonic Treatment." Dr. Olav Lindahl reviews his results of ultrasonic treatment for pain in the knees from arthrosis or chondromalacia, in 1952 and in the current year. Cases of lower extremity involvement and upper extremity involvement receiving supersonic treatment were compared with control groups. Results indicate 71 per cent of the controls showed improvement as compared to 57 per cent of the test knee cases, whereas only 18 per cent of the controls for upper extremity involvement improved as compared to 78 per cent in the upper extremity test group. This difference in response is not explained. Lindahl feels that ultrasonic treatment, with observation of necessary precautions, is one of the safest measures offered by physical medicine today.

—D. R. Street, 1st Lt., AMSC.

ANTERIOR DISLOCATION OF THE SHOULDER—A SIMPLE AND EFFECTIVE METHOD OF REDUCTION. William S. Smith, M.D., and T. J. Klug, M.D. *The Journal of the American Medical Association*, 163:3 (January 19) 1957.

The authors, in this paper, present a "simple, effective, atraumatic method of reduction of anterior dislocation of the shoulder" without the need of general anesthesia.

The procedure utilized is basically one outlined by Stimson in 1899. With certain modifications of the original technique, the current method of reduction is as follows. The patient in supine position is given an injection of 75 or 100 mg. of meperidine (Demerol) hydrochloride intravenously in the uninvolved arm; upon evidence of generalized relaxation with decreased muscle spasm he is turned to the prone position. The involved arm is then suspended over the side of the table or cart and a small sandbag placed under the midclavicular area. A weight carrier is attached to a hand stirrup by means of skin traction applied to the forearm. Two five pound weights attached to this device have been found to reduce the majority of anterior dislocations within a ten minute period, if necessary facilitated by an easy passive pendulum motion of the extremity. It is stated that weights should not be permitted to hang for over a 10 to 15 minute period; if no reduction is obtained in that time, conventional methods should be resorted to.

Results are favorable. In 30 consecutive cases of anterior dislocations, 75 per cent have seen reduction accomplished by this modification of Stimson's method. In all cases of recurrent dislocations has it proven successful. The authors urge the generalized use of this method as a safe, quick, relatively painless, and extremely effective means of reduction.

—Lt. D. R. Street, AMSC.

INDUSTRIAL INJURY—THE PRACTICAL NEED FOR EVALUATION OF CAPABILITY. Leonard J. Yamshon, M.D. *The Journal of the American Medical Association*, 165:8 (October 26) 1957.

This paper concerns itself with the place of evaluation of capability in the larger picture of rehabilitation. For the injured individual, a maximum reduction of disability and the increase of capabilities is essential for the protection of earning capacity.

It is felt that for either the severely disabled or for those with minor injuries, provisions for proper treatment have been made; but that for individuals with moderately severe injuries who anticipate a return to their former occupation or to some modification of it, sources of rehabilitation are lacking. The theoretical question at hand then is whether a practical realistic rehabilitation program is needed to accommodate this latter situation.

The responsibility in rehabilitation for determination of "employability" is reviewed, with the physician frequently the key figure. Factors receiving consideration include subjective and objective evaluation of the disability, the actual requirements of the job, and the individual's ability to fill them.

Attitudes encountered in physician, patient, and prospective employer as related to rehabilitation are studied. The lack of adequate reconditioning procedures in present treatment facilities is stressed as failing to simulate true working conditions.

The author presents a suggestion for an up-to-date rehabilitation program, to revolve around a center serving the dual purpose of treatment of disability and evaluation of capability. Distinction is made between this proposed center and a sheltered workshop, in regard to patient selection, remuneration, and disposition. The crux of the program would be reduction of disability, building of endurance (as differentiated from strength), general reconditioning and a functional evaluation. A positive objective medical viewpoint of the individual's working capacity, it is believed, can thus be achieved.

—D. R. Street, 1st Lt., AMCS.

SUITABILITY OF HOME CARE FOR THE CANCER PATIENT. I. Rossman, M.D. *Geriatrics*, 11:9 (September) 1956.

Nine years experience at Montefiore Hospital in New York City indicates that organized care of high quality can be made available to the cancer patient at home.

Such care was brought to the patient by a medical team composed of the physician, social worker, nurse, physical therapist and occupational therapist. Treatment and other problems relating to the patient's total welfare were the responsibility of the physician with the social worker handling the social and financial aspects of home care. Nursing needs from bed baths to more detailed bedside nursing were provided by the Visiting Nurse Service of New York on a contract basis. Education of the family was also provided by the nurse. Physical

therapy, under the direction of the physical medicine consultant, took the form of graded exercise programs, muscle strengthening and other rehabilitative procedures. Occupational therapy was planned on the basis of individual interest and stage of illness with its physical limitations.

In summary the author states that home care is outstanding in its supportive value as patients were more responsive to their environment, more alert and less of a management problem.

—Anna M. Doudlah, Lt., AMSC (OT)

USE OF SINGLE ILIAC BONE GRAFT TO REPLACE MULTIPLE METACARPAL LOSS IN DORSAL INJURIES OF THE HAND. Julian M. Bruner, M.D. *The Journal of Bone and Joint Surgery*, 39-A:1 (January) 1957.

Dr. Bruner presents two cases of damaged hands where reconstruction was carried out in stages: (1) pedicle-skin grafting, (2) bone grafting, and (3) tendon-grafting. In both patients the destroyed metacarpals were replaced by a single, full-thickness iliac-bone graft instead of by several struts inserted to replace individual metacarpals. The natural curve of the bone used corresponded to the concavity of the palm.

Dr. Bruner believes it is rarely possible to combine bone grafting and tendon grafting in the same operation as the post-operative management of these procedures is incompatible. Clear pictures accompany the article.

—Elizabeth J. Wood, 1/Lt., AMSC (OT)

CINEPLASTY. Colonel Ernest A. Brav, et al. *The Journal of Bone and Joint Surgery*, 30-A:1 (January) 1957.

This report of the value of the cineplasty procedure in military practice is the result of the combined study of the orthopedic service, the physical medicine service, and the Army Prosthetic Research Laboratory at Walter Reed Army Hospital. It covers a six year period from 1948 through 1953.

The authors point out that cineplasty should be performed at established amputation centers where all the members of the clinic team can participate in the management of the patient and that such operations should be limited to carefully selected patients.

Advantages and disadvantages of the cineplasty are discussed and recommendations are made concerning the usefulness of both biceps and pectoral cineplasty procedures.

—Elizabeth J. Wood, 1/Lt., AMSC (OT)

SOME PSYCHOLOGICAL CONCOMITANTS OF TUBERCULOSIS AND HOSPITALIZATION. John F. Muldoon, Ph.D. *Psychosomatic Medicine*, XIX:4 (July-August) 1957.

Eighty matched hospitalized males who were divided into four groups were selected for a statistical study of some psychological factors associated with tuberculosis and hospitalization. Two of the groups were tuberculous; two were non-tuberculous. One tuberculous and one non-tuberculous group were made up of patients who had been in the hospital less than three months. The two remaining groups had been in the hospital more than eleven months.

The Minnesota Multiphasic Personality Inventory was used to measure the variables of defensiveness, dependency, anxiety and repression.

There was no evidence of any effect of hospitalization on the measured psychological factors. The tuberculous subjects were significantly more dependent and less anxious than the non-tuberculous subjects. The results of this study support the conclusion that a basic dependency conflict is a possible contributing factor to the development of tuberculosis.

—Marilyn S. Trainer, 1-Lt., AMSC.

INTRAMEDULLARY FIXATION OF PATHOLOGICAL FRACTURES. E. W. Johnson, Jr., M.D. *The Journal of the American Medical Association*, 163:6 (February 9) 1957.

In this article the author discusses the advantages and limitations to the use of an intramedullary nail in pathological conditions of bone, particularly as found in fractures of the femur as a weight-bearing bone.

Aims of this form of treatment are summarized as follows: (1) to prevent complications of prolonged confinement to bed; (2) to reduce pain; (3) to facilitate definitive care; (4) to minimize extraosseous damage; and (5) to prevent pathological fracture.

In certain cases, three examples of which are presented, the insertion of an intramedullary nail is shown to contribute to the comfort of the hospitalized patient, to facilitate treatment, to promote earlier attempts at ambulation, or to reduce length of hospitalization.

Contraindications to this technique must include consideration of general risk of surgical procedure to debilitated patients, and the theoretical danger of distant spread of tumor tissue during insertion of the intramedullary nail, by direct or embolic means. Reference is made by the author to various sources to substantiate these viewpoints and findings.

—D. R. Street, 1-Lt., AMSC.

THE EVALUATION OF REHABILITATION IN THE INDIVIDUAL. Morton A. Seidenfeld, Melvin A. Glasser, Lawrence E. Abt, Saul H. Fisher, Pauline M. Ryman and Mary E. Switzer. *American Journal of Orthopsychiatry*, 27:1 (January) 1957.

This panel discussion, presented in 1955, was prompted by recognition of the necessity of establishing criteria for the evaluation of the rehabilitation process. In addition to the introduction by the chairman, Dr. Seidenfeld, five formal presentations were given.

The first presentation concerns community and group factors which affect the course and the outcome of rehabilitation programs. The second presentation deals with the assessment of rehabilitation potential and progress.

In the third presentation, the process of evaluation used on the rehabilitation service of Bellevue Hospital is described with an elaboration on what is looked for in the psychiatric evaluation in particular.

The fourth presentation deals mainly with the medical social worker's contribution as a member of the rehabilitation team. Also discussed are some of the various treatment goals, the importance of ADL training for the seriously disabled, and a few possible criteria for measuring the outcome of treatment and rehabilitation in the social area.

In the last presentation, the author reviews the criterion that is used to judge the outcome of rehabilitation services in the public vocational rehabilitation program. This criterion is as follows: "employment in a remunerative occupation that is in line with the aptitudes, abilities and limitations of the handicapped individual." The author shows how this equating of rehabilitation with suitable employment is both valid and constructive and cites several studies of the outcome of rehabilitation services.

—Anne D. Lyman, 1st Lt., AMSC

CURRENT STATUS OF THE TREATMENT OF RHEUMATOID ARTHRITIS. W. Paul Holbrook, M.D., Donald F. Hill, M.D., and Charles A. L. Stephens Jr., M.D. *The Journal of the American Medical Association*, 164:13 (July 27) 1957.

In as much as rheumatoid arthritis is a chronic disease, emphasis should be placed on long term treatment. If the physician will spend sufficient time and effort to establish his patient on a sound basic program and select elective measures best suited to the individual problem, the results of treatment will be surprisingly rewarding.

Once the patient is established on a full basic program, the physician is free to choose elective procedures such as transfusions, gold salts, change of climate, glucocorticoids, anti-inflammatory agents, X-ray therapy, corticotropin and phenylbutazone.

—Marilyn S. Trainer, Lt., AMSC (OT)

THE TREATMENT OF ULCERATIVE COLITIS. Joseph B. Kirsner, M.D., Richard O. Bicks, M.D., and Walter L. Palmer, M.D. *Archives of Internal Medicine*, 99:4 (April) 1957.

Uulcerative colitis is an acute and chronic disease of the colon and rectum, treatment is symptomatic and adapted to the patient. Because of its prolonged course and frequent complications, the disease imposes many problems upon the patient, his family and his physician.

Though the incidence of psychiatric problems in these patients is high, formal psychiatric treatment is seldom indicated. Supportive therapy to develop a more mature orientation to life, along with changes in home life and environment, may be beneficial.

—Isabel C. Cella, Lt., AMSC.

Georgia Warm Springs Foundation

GRADUATE COURSE

Physical Therapy and Occupational Therapy

In the Care of *Neuro-Muscular Disease*

This course is open to graduates of approved schools of physical and occupational therapy. Such graduates must be members of the American Physical Therapy Association and/or American Registry of Physical Therapists, or American Occupational Therapy Association.

Entrance dates: First Monday in January, April and October.

Course I—Emphasis on care of convalescent neuromuscular disease with intensive training in functional anatomy, muscle testing, muscle reeducation and use of supportive and assistive apparatus. This course is complete in itself.

Course II—Three months duration with course I prerequisite. Emphasis on care of severe chronic physical handicaps with intensive training in resumption of functional activity and use of adaptive apparatus.

In-Service Training Program—Fifteen months duration at salary of $225 per month plus full maintenance, increasing to $250 per month at the completion of nine months. This program includes training in course I and II.

Tuition: None. Maintenance is $100 per month. For scholarship to cover transportation and maintenance for course I and II, contact National Foundation for Infantile Paralysis, Inc., 301 East 42nd St., New York 17, N. Y. (Scholarships require two years of experience.)

For further information contact:

ROBERT L. BENNETT, M.D.
Medical Director

Georgia Warm Springs Foundation
WARM SPRINGS, GEORGIA

CHILDREN'S REHABILITATION INSTITUTE FOR CEREBRAL PALSY

POST GRADUATE COURSE

OCCUPATIONAL THERAPY TECHNIQUES OF TREATMENT IN CEREBRAL PALSY

UNDER DIRECTION OF:

Winthrop M. Phelps, M.D.
Medical Director

An intensive eleven week course inclusive of 144 lecture hours and 213 clinical hours in treating a varied caseload while apprenticed to an experienced registered therapist. Detailed discussions of self-help techniques, records, equipment and all phases of a total program for the cerebral palsied for all types of communities.

COURSE DATE:

July 7 through Sept. 19, 1958
Oct. 6 through Dec. 19, 1958
Jan. 5 through March 20, 1959

Enrollment must be processed and approved three weeks prior to course date.

TUITION: $150 for full 11 weeks

For further information contact:

RUTH W. BRUNYATE, O.T.R.

Administrative Assistant

CLASSIFIED ADVERTISING

Classified advertising accepted for POSITIONS WANTED and POSITIONS AVAILABLE only. Minimum rate $3.00 for 3 lines; each additional word ten cents. (Average 56 spaces per line). Copy deadline first of each month previous to publication.

POSITIONS AVAILABLE

Immediate opening for qualified registered occupational therapist, 400 bed tuberculosis sanitarium. Beginning salary $337 monthly with periodic increases; 40 hour week; 2 weeks vacation; 11 paid holidays. Student training program. Hospital in medical center, easily accessible. Apply: Dr. Karl H. Pfuetze, Medical Director, 1919 West Taylor Street, Chicago 12, Illinois.

Challenging positions available for OTR's in New Jersey's largest state mental hospital with opportunity available for professional growth. Progressive, well equipped department under direction of Mrs. Lucille Boss, O.T.R. Staff conferences, excellent guidance. Staff salary $4200-$5100, Sr. $4360-5460. Full maintenance approximately $400 annually. Apply Personnel Department, New Jersey State Hospital, Greystone Park, N. J., (approximately 30 miles west of New York City—near Morristown, N.J.)

Director occupational therapy in progressive psychiatric hospital. Salary $5529-$7055, liberal fringe benefits. Write Activity Program Coordinator, Allentown State Hospital, Allentown, Pennsylvania.

One occupational therapist wanted for full-time position in private mental hospital. Average census 60 patients. Progressive psychiatric program. Address: Mrs. Heide F. Bernard, Administrator, Hall-Brooke, Greens Farms, Connecticut.

Position open for a registered occupational therapist in a 1600 bed, progressive mental hospital. Salary range is $4020 to $5100 with good living quarters available. Located on the Ohio River between Louisville, Kentucky, and Cincinnati, Ohio. Recent graduates accepted. Contact Hazel C. Tendo, O.T.R., Madison State Hospital, Madison, Indiana.

Registered occupational therapist (female) to develop and head new department in 192-bed geriatric institution. New OT facilities to be included in new building to be constructed in 1959. Three weeks paid vacation, sick leave, holidays, 5-day week, meals. Salary $4800 to $5400. Position open October 1st. Write: Administrator, River Bluff Nursing Home, N. Main Road, Rockford, Illinois.

Occupational therapist to take full charge of an active department in a 350 bed general teaching hospital and to be in charge of occupational therapy students from an affiliated school. 44 hour week, one month's vacation plus other liberal personnel benefits. Salary $4,600 per year. Write Mr. Edwin L. Taylor, Director, The Graduate Hospital, Philadelphia 46, Pa.

Position open, Saint Albans Psychiatric Hospital, Radford, Virginia. Recreation and occupational therapy director for 120 bed private psychiatric hospital located in southwest Virginia. Prefer young woman who has completed training—interested in a challenging situation. Wonderful opportunity for growth. Address inquiries: Don Phillips, Administrator, Box 1172, Radford, Virginia.

Occupational therapist in private psychiatric hospital (O.T.R.). Work includes recreation and entertainment as well as the occupational therapy program for both women and men. Maintenance is provided. Salary open. Apply to Clifford D. Moore, M.D., Medical Director, Stamford Hall, Stamford, Connecticut.

Excellent opportunities for occupational therapists to use knowledge and abilities in developing a progressive, dynamic program. Located in suburban Louisville, Kentucky, which offers educational and cultural advantages. Starting salary per year $4296, 40 hour week, paid vacation and sick leave, 13 holidays per year, opportunity for advancement to supervisory posisitions. Contact Miss Margaret Biener, Director of O.T., Central State Hospital, Lakeland, Kentucky.

Occupational therapist, registered, staff level; interested in working with amputees, polios, paraplegics, cerebral palsy and related diagnoses. Rehabilitation hospital with present bed capacity of 65 beds. Planning now underway for expansion of in-patient and out-patient facilities. Progressive personnel policies. Salary commensurate with experience and training. Apply Administrator, Eastern N.Y. Orthopaedic Hospital-School, Inc., 124 Rosa Road, Schenectady 8, New York.

Wanted: Assistant director of occupational therapy interested in extensive occupational-industrial therapy program for 3000 bed A.P.A. approved psychiatric teaching hospital. Salary $5500-$7050.00, 40 hour week, 15 days vacation and 13 holidays. Civil service and retirement benefits. Write: Miss Olive Bostrom, O.T.R., Director of Occupational Therapy, Warren State Hospital, Box 240, Warren, Pennsylvania.

Long Island Hospital, the chronic division of the Boston Hospital Department has two positions open for occupational therapists to work with two rehabilitation programs: (1) Physical disabilities. (2) Alcoholic research. These programs are supervised by doctors who teach at the Boston School of Occupational Therapy Yale University School of Alcoholic Studies recognizes the alcoholic program. 40 hour week—$67.75 to $75.25 per week—vacation—sick benefits—maintenance if desired. Contact Jane Welch, Supervisor, Occupational Therapy Department, Long Island Hospital, Boston 69, Massachusetts.

Registered occupational therapist to develop and maintain program for new 100 bed psychiatric unit in large midwest hospital. Salary open. A wonderful opportunity for the right person. Address Box 25, American Journal of Occupational Therapy, 3514 N. Oakland Ave., Milwaukee, Wis.

Occupational therapist for Cerebral Palsy Treatment Center. Fully equipped. Good working conditions. Excellent salary. Scholarship funds available for additional training. Write Herman L. Rudolph, M.D., 400 North Fifth Street, Reading, Pennsylvania.

Qualified occupational therapist for out-patient cerebral palsy treatment center. Liberal salary. Two month vacation, sick leave. Liberal personnel policy. Contact Robert Schlitt, Director, Peninsula Cerebral Palsy Training Center, 901-24th Street, Newport News, Virginia.

Registered occupational therapists for new modern admissions building in psychiatric hospital 12 miles out of Boston. Salary range $3,497-$4,511. For further information contact Miss Helen Storr, OTR, Head Occupational Therapist, Metropolitan State Hospital, Waltham 54, Mass.

Wanted: Occupational therapists, men and women, for a full approved, large psychiatric hospital in New England, midway between New York and Boston. Active in teaching and research. Large, new occupational therapy center, "the building of tomorrow." New and modern equipment, dynamic all-inclusive treatment program for patients. Large affiliating student group with excellent education program. Modern home, maintenance optional. Liberal retirement plan and illness policy. Paid vacations and holidays, automatic increments. Rotating services which offer professional growth.

Immediate appointments, Write: Harry Kromer, O.T.R., Norwich State Hospital, Norwich, Connecticut.

Assistant director, modern tuberculosis hospital with affiliation program. Close liaison with active state rehabilitation program. Patient rehabilitation conferences with heads of professional services. Five-day, 40-hour week, paid vacations, 7 holidays, sick leave, social security. Excellent opportunity for progressive administrator. Send resume to Mrs. May Yokoyama, Director, Occupational Therapy, Emily P. Bissell Hospital, 3000 Newport Gap Pike, Wilmington 8, Delaware.

Openings for two occupational therapists in a 3300 bed psychiatric hospital. Salary range $3660-$5928. Apply at St. Louis State Hospital, 5400 Arsenal, St. Louis, Mo.

Supervising occupational therapist for outpatient rehabilitation center. Caseload primarily chronically ill or pre-vocational. Salary range $4600-$6300. 35 hour week. Position available in September. Write Gerald E. Cubelli, Executive Director, Mobility, 427 Main Street, New Rochelle, New York.

Wanted: OTR, female with psychiatric experience. To assume responsibility, after a period of indoctrination, for 45-bed private unit. Benefits—board/room, Blue Cross, sick leave, social security, insurance policy after one year, other standard benefits. Salary open. Elmcrest Manor, 25 Marlborough St., Portland, Conn.

Immediate placen ent for registered, qualified occupational therapist for supervisory position in rapidly expanding physical medicine and rehabilitation institute serving two hospitals, total 1,000 general medical and surgical beds, in largest centrally located industrial center in Illinois. Experience in supervisory position and in comprehensive rehabilitation center necessary. Salary $4,800-$5,400. Write: Administrator, Institute of Physisal Medicine and Rehabilitation, 619 North Glen Oak Avenue, Peoria, Illinois.

Immediate opening for occupational therapist, with degree. Special school for physically handicapped. Cerebral palsy experience desirable. Apply, Mrs. Andrew Witengier, Coordinator of Medical Services, Forrest Park School, 1600 Silver Star Road, Orlando, Florida.

Occupational therapist for expanding department. Beginning salary $4000 for inexperienced therapist. Good personnel policies, paid vacation, sick leave, Blue Cross-Blue Shield, annual salary increment, 37½ hour week. Crossroads is in a beautiful new building, well equipped and nationally recognized as a leader in the field of rehabilitation. This is a real opportunity. Write Roy E. Patton, Executive Director, Crossroads Rehabilitation Center, 3242 Sutherland Ave., Indianapolis, Indiana, or call WAlnut 6-2482.

O.T.R. for staff position in new 50-bed rehabilitation hospital. Newly equipped department treating polio, orthopedic and cerebral palsied children. Three weeks' vacation, Blue Cross and 40-hour work week. Write: Administrator, Crippled Children's Hospital, 200 Henry Clay Avenue, New Orleans, La.

INDUSTRIAL THERAPIST IV

Male O.T.R., with a background in a psychiatric hospital and/or in the field of rehabilitation, to organize a comprehensive rehabilitation program, utilizing tasks available in the various hospital industries in a therapeutic manner and toward the total rehabilitation of the patient. This is a new position at Mendota State Hospital, Madison, Wisconsin, a diagnostic and intensive treatment hospital. The position would have department head status along with the directors of psychology, social service, nursing, occupational therapy and recreational therapy.

Responsibilities include job analysis, patient placements, development of training programs and close liaison with state physicians for effective patient placements.

Educational, cultural, social and recreational opportunities are unlimited in this city, located in the heart of Wisconsin's vacationland.

Four years' experience with two years at a supervisory level are desirable. The salary range is $5760 to $6900 with yearly increments based on merit.

Write Dr. Walter J. Urben, Superintendent, Mendota State Hospital, Madison, Wisconsin.

Occupational therapist to establish occupational therapy section of new children's rehabilitation center. Entire center and operation new. Occupational therapy center equal status with other co-medical sections. Persons applying must be qualified and willing to assume chief rating in year or so. Salary open and commensurate with qualifications. Refer replies to Dwight M. Frost, M.D., Medical Director, 600 Doctors Building, Omaha, Nebraska (5).

Immediate opening for registered therapist in university hospital affiliated with medical school. Active, expanding, air conditioned department. Physical disabilities with out and in patients; rehabilitation in regional polio center; psychiatric and pediatric programs. 40 hour week, one month vacation, 2 weeks sick leave, social security and Blue Cross benefits. Write: Miss Nancy Vail, O.T.R., Director Occupational Therapy, Vanderbilt University Hospital, Nashville, Tennessee.

Director for occupational therapy dept. required for 450 bed modern geriatric agency. Stimulating challenge for imaginative, registered therapist to conduct dynamic program. Salary open. Excellent personnel practices. Attractive living quarters available. Menorah Home & Hospital for Aged, 871 Bushwick Ave., Brooklyn 21, N. Y.

Wanted: Staff occupational therapist for the Suburban Cook County Tuberculosis Sanitarium District, Hinsdale, Illinois (suburb of Chicago). Expanding program, 225 bed hospital. New OT shop. Starting salary $4200-4500, dependent on experience. Two weeks vacation, 12 days sick leave, 11 holidays, plus other employee benefits. Maintenance available. Write to: Miss Ellen Harenburg, O.T.R., 55th & County Line Road, Hinsdale, Illinois.

Immediate opening for occupational therapist, registered or eligible for registration. Acute intensive treatment psychiatric hospital with student affiliation, research and teaching programs. Located in large university medical center. Modern recreational facilities available. Salary range $4020 to $6300; beginning salary commensurate with experience. Contact Virginia L. Caskey, O.T.R., Coordinator of Activity Therapy, Larue D. Carter Memorial Hospital, Indianapolis 7, Indiana.

Wanted immediately: Director of OT and staff OT for Missouri State Hospital No. 1. Work covers main shop and four building shops. Areas all currently well-staffed and additional personnel being added. Psychiatric treatment program well established. Contact Vernon McConnell, Personnel Director, State Hospital No. 1, Fulton, Missouri.

Registered OT wanted in flexible rehabilitation program with endowed United Fund agency for blind and partially sighted persons of all ages. Opportunity for further developing children's therapeutic and recreational program and dynamic individual adult rehabilitative OT program offering pre-vocational training, activities of daily living, orientation training for homemakers and some homebound. Medical direction and psychiatric consultation incorporated in agency team approach and with other rehabilitative agencies and community facilities. Salary $4000 to $4800, depending on experience; 4 weeks annual vacation; uniform laundry and other extensive fringe benefits. College town, excellent medical center, cultural advantage, 185,000 population and center of recreational area—near Lake Michigan. Contact Mr. F. C. Lindberg, Executive Secretary, Association for the Blind and for Sight Conservation, 338 Sheldon Ave., S.E., Grand Rapids, Michigan.

Immediate openings for registered occupational therapists and graduates of approved schools eligible for registration, in 2000 bed chronic disease hospital affiliated with New York Medical College. Positions available in children's rehabilitation (primarily cerebral palsy), adult rehabilitation, and ward program. Five day week, four weeks paid vacation, eleven holidays, twelve days sick benefit. Salary $3750-4830. Write Mrs. Carolyn Aggarwal, O.T.R., Bird S. Coler Hospital, Welfare Island, New York 17, N. Y.

Staff occupational therapist: needed at Iowa Methodist Hospital, Des Moines, Iowa. Hospital has 400 beds, including Raymond Blank Memorial Hospital for Children. Construction underway of 120-bed rehabilitation unit. Excellent chance for advancement. In- and outpatient work. Competent professional staff and assistants. Excellent working relationships. Apply Personnel Director.

Registered occupational therapists for California rehabilitation programs in mental hospitals and the Veterans' Home. Starting salaries $376, $436, and $530 depending on experience. Promotional opportunities in mental hospitals. Attractive employee benefits. Write Medical Personnel Services, State Personnel Board, 801 Capitol Avenue, Sacramento, California.

Registered occupational therapist—for 53-bed progressive Jewish home for older chronically sick people. New building, excellent facilities, rehabilitation team approach. Salary $4,000.00 plus other benefits. Contact Leon R. Cantor, Executive Director, Beth Sholom Home of Virginia, Libbie & Fitzhugh Aves., Richmond 26, Virginia.

Chief psychiatric occupational therapist for university teaching hospital. Therapist considered essential member of therapeutic team. Department conducts clinical training program. Prefer candidate with supervisory experience. Write details of experience, education and salary desired to Personnel Office, University of Colorado Medical Center, 4200 East Ninth Ave., Denver 20, Colorado.

OT wanted for rehabilitation program in small (175 bed) general hospital. Unusually good facilities. 5 day week; 4 week paid vacation; holidays; sick leave; Blue Cross. Room, board and laundry available. Salary $4200. Write Julie Phelan, O.T.R., Our Lady of Fatima Hospital, N. Providence, Rhode Island.

Registered occupational therapist for permanent position in modern 250 bed general hospital. Northeast Ohio area. Primary duties would be in connection with orthopedic department known as Gates Hospital for Crippled Children. Write Personnel Director, Elyria Memorial Hospital, Elyria, Ohio.

Well established rehabilitation center has two openings for staff therapists. (1) Physical disabilities—functional treatment, ADL training and pre-vocational exploration. (2) TB program—in new air-conditioned building. Teaching, research and medical center with 1200 bed hospitals. City rich in educational, cultural and recreational facilities. Forty-hour week with liberal benefits. Salary $3456 to $4320. Write Miss Beverly Bates, Director, Occupational Therapy Department, Medical College of Virginia, Richmond, Virginia.

A Complete Line of Ceramic Supplies

CLAY — BRUSHES
GLAZE — PATTERNS
MOLDS — KILNS
COLORS — SUPPLIES

FREE PERPETUAL CATALOG
When requested on your institution letterhead
Others please send $1.00

WILLOUGHBY STUDIO
407 East Florence Avenue — Inglewood 1, California

For Treatment of
SPASTIC CASES • CEREBRAL PALSY • STROKE • POLIO
HAND INJURIES

GENERAL ELECTRIC COMPANY'S SILICONE
BOUNCING PUTTY
Does Not Harden • Lasts Indefinitely
Can Be Autoclaved

OCCUPATIONAL THERAPY
As A "Trial Order"—Send $2.00 For One $2.85 Jar

S. R. GITTENS, Sole Distributor
1620 Callowhill St., Philadelphia 30, Pa.

COMPLETE LINE OF QUALITY HANDICRAFT SUPPLIES

COLORS • LINKBELTS • METAL ENAMELING
TISTS • CRAFTSTRIP • METAL CRAFT
• CRAFT BOOK • WOODEN BOXES
UPPLIES • BLOCK PRINTING
CRAFT • WOODEN PLATES
TS • ARTISTS SUPPLIES
AFT • CHIP CARVING
K • TEXTILE COLORS
• GLASS ETCHING
NG • LEATHERCRAFT

FREE CATALOGUE ON REQUEST

GAGER'S HANDICRAFT
1024 NICOLLET AVE.
MINNEAPOLIS, MINNESOTA
FEderal 5-6757

It Pays to Use the Classified Section of the

AMERICAN JOURNAL OF OCCUPATIONAL THERAPY

DO YOU HAVE A VACANCY IN YOUR DEPARTMENT?

An ad under "positions available" in the **American Journal of Occupational Therapy** reaches all registered occupational therapists who are members of the American Occupational Therapy Association. Therefore if you have a vacancy in your department, your ad will be read by occupational therapists interested in your department, your city, or the challenge your position offers.

DO YOU WANT A CHANGE OF POSITION?

An ad under "positions wanted" will reach department directors and hospital administrators interested in an occupational therapist for a vacancy in their department, for a new position or for a new department. No other magazine is published exclusively for occupational therapy so you can be certain the classified section of the Journal will be a reference for those seeking personnel.

Classified Advertising Department
American Journal of Occupational Therapy
3514 North Oakland Avenue, Milwaukee 11, Wisconsin

Please schedule the following advertisement for the _____ issue(s) of the American Journal of Occupational Therapy under the following heading:

_____Positions Available _____Positions Wanted

_____

_____

_____

_____

_____

_____

☐ **Check or money order enclosed**
☐ **Bill the hospital**

Signed_____
Title_____
Hospital_____
Address_____
City_____ Zone_____
State_____

INFORMATION ON THIS LOW-COST SERVICE:

Minimum rate $3.00 for 3 lines; each additional word ten cents. (Average 56 spaces per line.)

Deadline: First of the month previous to publication.

The American Journal of Occupational Therapy is published bimonthly in the even months of February, April, June, August, October and December.

Classified advertising is the lowest cost method of advertising available.

Schools Offering Courses in Occupational Therapy

Boston School of Occupational Therapy, Affiliated with Tufts University, 7 Harcourt St., Boston, Mass. *Mrs. John A. Greene, President.*

Buffalo, University of, School of Medicine, 3435 Main St., Buffalo 14, N. Y. *Asst. Prof. Nancie B. Greenman, O.T.R., Director of Program in O.T.*

Colorado State University, Fort Collins, Col. *Asst. Prof. Marjorie Ball, O.T.R., Director of O.T.*

Columbia University, College of Physicians and Surgeons, 630 W. 168th St., New York 32, N. Y. *Ass't. Prof. Marie Louise Franciscus, O.T.R., Director of Training for Occupational Therapy.*

Eastern Michigan College, Ypsilanti, Michigan, *Assoc. Prof. Frances Herrick, O.T.R., Director of O.T.*

Illinois, University of, College of Medicine, 1853 West Polk St., Chicago 12, Ill. *Assoc. Prof. Beatrice D. Wade, O.T.R., Director of O.T.*

Iowa State, University of, College of Liberal Arts and College of Medicine, Iowa City, Iowa. *Ass't. Prof. Elizabeth Collins, O.T.R., O.T. Supervisor.*

Kalamazoo School of Occupational Therapy, Western Michigan University, Kalamazoo 45, Michigan. *Assoc. Prof. Rosalia Kiss, O.T.R., Director of O.T.*

Kansas, University of, School of Occupational Therapy, Lawrence, Kansas. *Assoc. Prof. Frieda Congello, O.T.R., Director of O.T.*

Mills College, Oakland 13, Calif. *Miss Elizabeth Fuchs, O.T.R., Director of O.T.*

Milwaukee-Downer College, 2512 E. Hartford Ave., Milwaukee 11, Wis. *Prof. Henrietta McNary, O.T.R., Director of O. T.*

Minnesota, University of, School of Medical Sciences, Minneapolis, Minn. *Assoc. Prof. Borghild Hansen, O.T.R., Director of O.T.*

Mount Mary College, Milwaukee 10, Wis. *Sister Mary Arthur, O.T.R., Director of O.T.*

New Hampshire, University of, College of Liberal Arts, Durham, N. H. *Miss Anne Henderson, O.T.R., Supervisor of O.T.*

New York University, School of Education, Washington Square New York 3, N. Y. *Assoc. Prof. Frieda Behlen, O.T.R., Director of O.T.*

North Dakota, University of, Grand Forks, N. D. *Asst. Prof. Amy Lind, O.T.R., Director of O.T.*

Ohio State University, College of Education, Columbus 10, Ohio. *Miss Barbara Locher, O.T.R., Chairman, O.T. Dept.*

Pennsylvania, University of, School of Auxiliary Medical Services, 419 South 19th Street, Philadelphia 46, Pa. *Prof. Helen S. Willard, O.T.R., Director.*

Puerto Rico, University of, School of Physical and Occupational Therapy, Professional Bldg., Santurce, Puerto Rico. *Mr. E. Lopez-Fernandez, O.T.R., Technical Director of O.T.*

Puget Sound, College of, Tacoma 6, Wash. *Asst. Prof. Shirley Bowing, O.T.R., Director, School of O.T.*

Richmond Professional Institute, College of William and Mary, Richmond 20, Va. *Miss H. Elizabeth Messick, O.T.R., Director of O.T.*

Saint Catherine, College of, St. Paul 1, Minn. *Sister Jeanne Marie, O.T.R., Director of O.T.*

San Jose State College, San Jose 14, Calif. *Prof. Mary Booth, O.T.R., Director of O.T.*

Southern California, University of, College of Letters, Arts and Science, Box 274, Los Angeles 7, Calif. *Assoc. Prof. Angeline Howard, O.T.R., Director of O.T.*

Texas Woman's University, Dept. of Arts, Denton, Texas. *Assoc. Prof. Rena Worthington, O.T.R., Director, School of O.T.*

Texas, University of, Medical Branch Galveston, Texas. *Miss Rose Marie Wells, O.T.R., Director of O.T.*

Washington University, School of Medicine, 4567 Scott Ave., St. Louis 10, Mo. *Asst. Prof. Martha Matthews, O.T.R., Director, Dept. O.T.*

Wayne State University, College of Liberal Arts, Detroit 1, Michigan. *Asst. Prof. Barbara Jewett, O.T.R., Chairman, O.T. Dept.*

Wisconsin, University of, School of Medicine, 1300 University Ave., Madison 6, Wis. *Asst. Prof. Caroline G. Thompson, O.T.R., Director of O.T.*

Awaiting accreditation:

Indiana University, College of Medicine, 1200 West Michigan Street, Indianapolis 7, Ind.